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VOLUME 8 • JUNE 1953 • NUMBER VI

# Journal of the AMERICAN MEDICAL WOMEN'S ASSOCIATION

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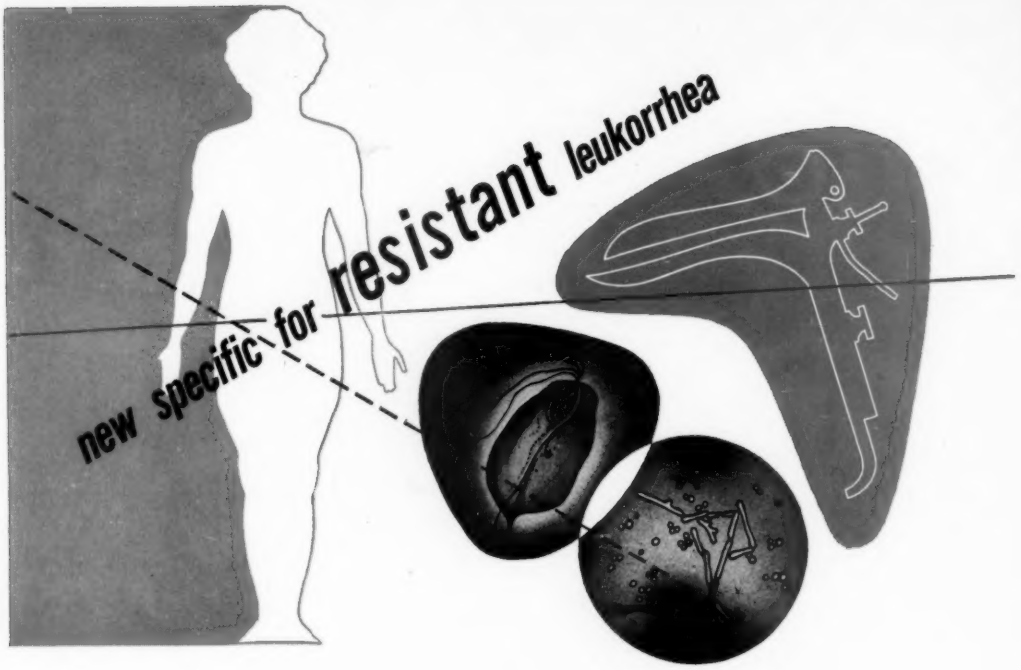


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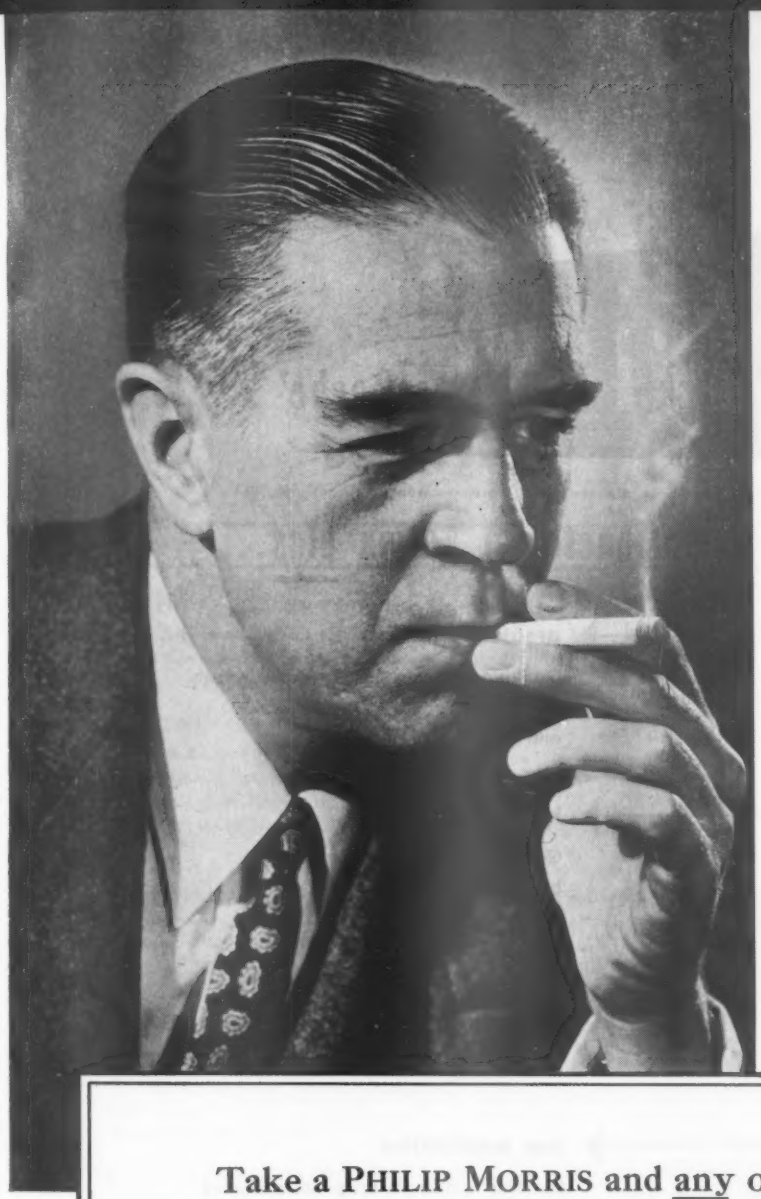

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JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION is published monthly by the American Medical Women's Association, Inc., at 136 4th Ave., Nashville 3, Tenn. Entered as second class matter at the Post Office at Nashville, Tennessee, under the Act of August 24, 1912. Acceptance for mailing at special rates of postage provided for in Section 1102, Act of October 8, 1917, and authorized July 15, 1918.


Copyright 1953 by the American Medical Women's Association, Inc.


Subscription, $5.00 per year; $1.00 single copy.
EDITORIAL AND ADVERTISING OFFICE, Journal of the American Medical Women's Association, V. Brookhart, Advertising and Business Manager, 1790 Broadway, New York 19, N. Y. Telephone Judson 6-8683.

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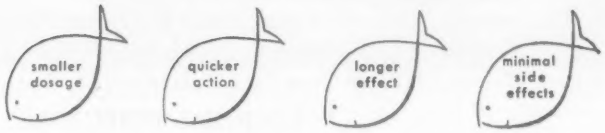

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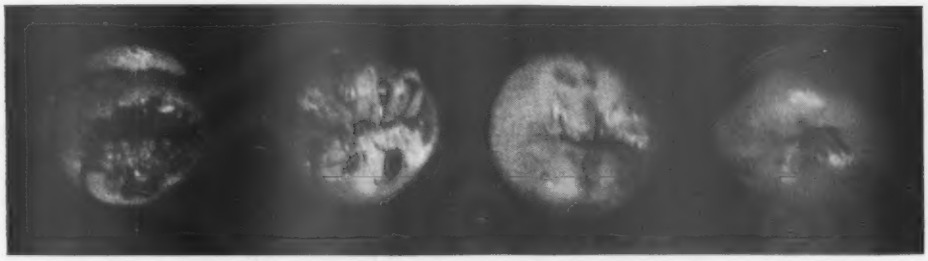

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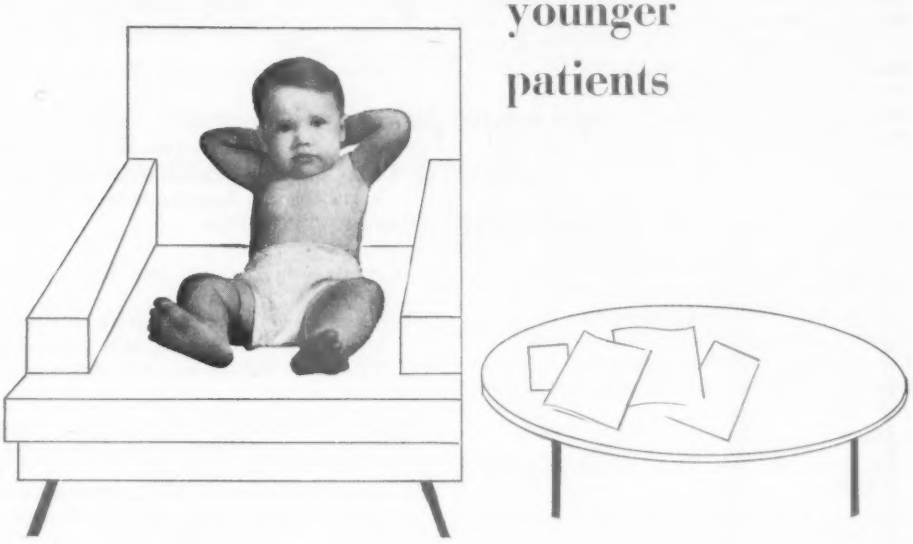

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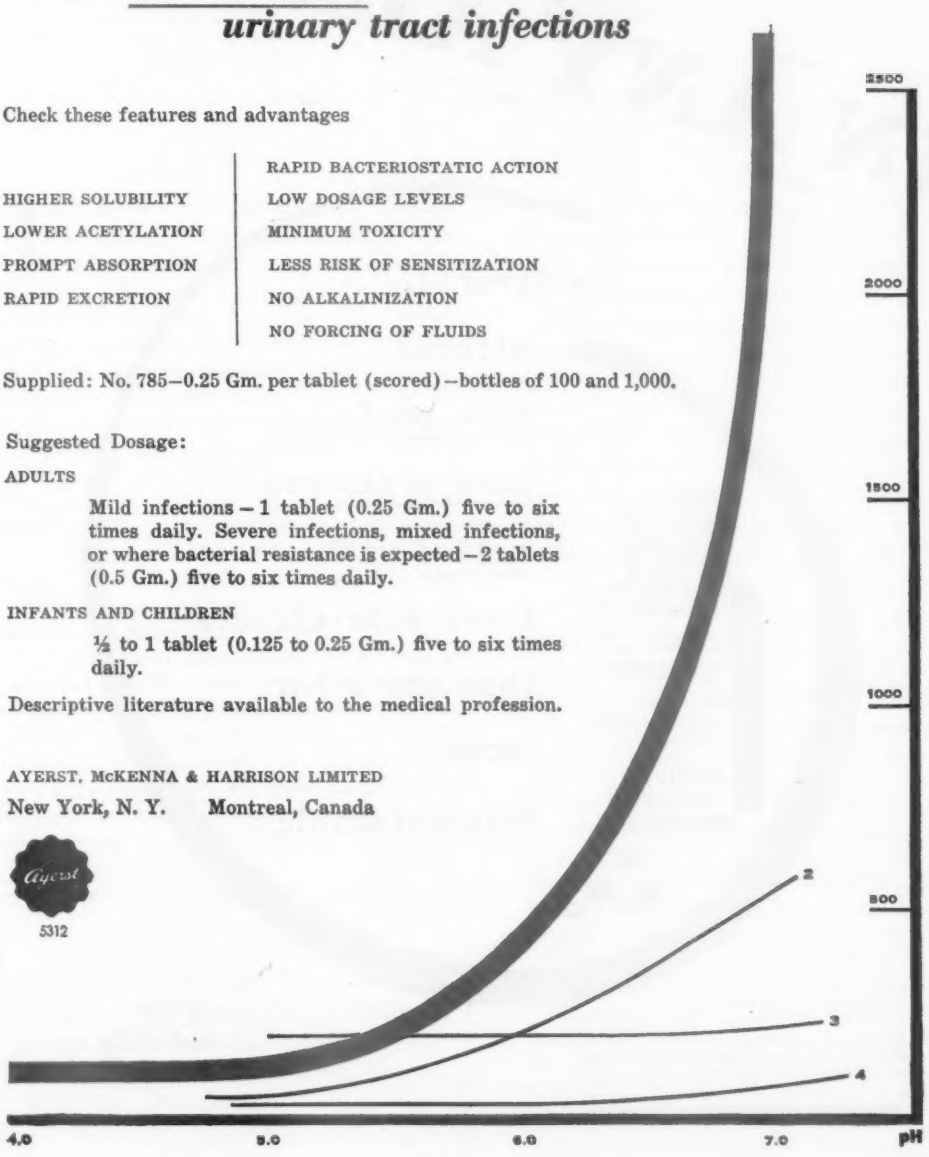

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# Some Aspects of Chronic Cough

Emily Lois Van Loon, M.D., F.A.C.S.

THE ENTIRE SUBJECT of chronic cough cannot, of course, be adequately presented in one short paper, so this discussion will emphasize those phases of chronic cough where the etiology is found in the upper respiratory tract. Also, without giving a symposium on the subject of endoscopy, there are mentioned some cases where, without the endoscopist, the patient would have continued to cough. The chronic cough may respond promptly to a course of antibiotic therapy or may tax the diagnostic and therapeutic skill of the internist, the roentgenologist, the laryngologist, and even the psychiatrist. Some of the cases presented are those in which patients with chronic cough have been referred to the laryngologist and the cough has been controlled—ignoring the ones who returned to their internist with the cough unchanged.

For the sake of completeness, there should be mentioned first the cough of the child with large adenoids, and resulting thick secretion in the nose and pharynx. Diagnosis of this cough is not difficult when we note the enlarged cervical glands, stuffy nose, large tonsils, and the thick mucus draining from the nasopharynx. In doubtful cases, the nasopharyngoscope or a quick examining finger in the nasopharynx confirms the impression. The adenoid cough is usually worse when the patient lies down and therefore is apt to interfere with the little patient's sleep. It is usually most successfully treated by surgical removal of the diseased tissue. Occasionally improved hygiene and nutrition, or the use of roentgen ray or radium will reduce the amount of infection and of the cough-producing secretion, but in most instances surgery is much more effective.

Cough from the presence of secretion in the pharynx also occurs in sinusitis. Purulent secretion draining down the pharynx is almost pathognomonic of sinusitis. Careful examination of the nose will usually reveal the source of the secretion, and with adequate treatment, and surgery if necessary, the cough can be eliminated. The silent, asymptomatic sinus infection should not be overlooked as a cause of cough. This was vividly illustrated by a colleague who, while reading a paper, was so disturbed by a constant, dry, irritating cough that she could hardly finish the presentation. She had no sinus tenderness, no nasal or postnasal discharge, and no abnormal chest findings. Sinus roentgenogram revealed a completely opaque antrum. Irrigation of the antrum produced old, foul pus which apparently had been present for a long time and, as the antrum cleared, the cough disappeared. This silent antrum infection may be completely lacking in local signs or symptoms. We see it sometimes as an exciting factor in bronchiectasis and in asthma. In an unexplained, resistant cough, a sinus roentgenogram will sometimes give us the answer. However, detailed treatment of sinusitis is not within the scope of this paper.

Postnasal secretion which irritates the pharynx is often not purulent but mucoid. The etiology of this

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mucus can be varied indeed. Hypertrophied turbinates may cause it, or environmental irritation from smoke, dust, paint, and so forth, can stimulate overproduction of mucus. In the young patient, stuffy nose and postnasal secretion are often associated with excessive carbohydrate in the diet. Sometimes it occurs as a response to temperature change, increased humidity, or to other sudden changes in climate. Some patients find this mucus disappears completely when they are in the mountains; a few are benefited by the climate of the seashore. Occasionally there is a history of definite allergy. With this varied picture it is difficult to organize a plan of treatment.

We always suspect allergy; in fact, with the antibiotics largely controlling infections, and with our increasing appreciation of the role of allergy, the otolaryngologist is rapidly becoming an allergist. These patients should be studied as to diet, environment, exercise, living conditions, and so forth. Some will co-operate and obtain good results; others refuse to give the time necessary for adequate allergic evaluation. Some have consulted or will consult the allergist, perhaps with no specific cause for the symptoms being found. In a number of these patients, we have been using small desensitizing doses of histamine and of house dust with considerable success. This is not a new idea. Marvin Jones mentioned it in an article about allergic rhinitis published in *Laryngoscopy,* July 1950. If the patient has frequent colds and shows congested membranes, we often administer a combination of histamine with stock vaccine, and thereby reduce the postnasal secretion. This treatment has the advantage of simplicity, and a surprising number of patients report definite diminution of the mucus in their throats.

We are guided in our choice of medication by the result of the histamine skin test, by the history of response to dust, and so forth, and by the degree of congestion in the nose. As an example, one young man who came in recently complained of severe headache, cough, nasal obstruction, and typical symptoms of respiratory infection. He had been treated during a previous similar episode and it was found that antibiotics and sinus treatment were quite unsuccessful. On this occasion we treated him with histamine and stock vaccine. His cough and headache were relieved within a few days.

Whatever the etiology of the discharge, the constant presence of secretion in the throat tends to cause hypertrophy of the pharyngeal lymphoid tissue. Older rhinologists have said that hypertrophied lymphoid tissue was pathognomonic of sphenoid sinus disease. This is questionable. Certainly this tissue does become infected and hypertrophied when the pharynx is bathed in infected secretion. But we also see it frequently when there is neither secretion present nor do we get a history of such. Possibly it is a sequela of acute pharyngitis. Whatever the etiologic factors, and there are many, this tissue is the trigger area for a tremendous percentage of the coughs seen by the otolaryngologist. The patient's complaints are characteristic; paroxysms of unproductive, tickling cough, often precipitated by minor irritations such as cold air, acid food, toast, and so forth, which usually occur at embarrassing times.

A history such as this should lead one to make a thorough examination of the nasopharynx, pharynx, and hypopharynx. Hypertrophied tissue anywhere in the entire pharynx may be the trigger area for the cough mechanism. Occasionally the symptoms come from the tissue in the nasopharynx behind the eustachian eminence. Most frequently, the tissue is on the lateral pharyngeal wall, behind the posterior pillars. Occasionally it is red and as thick as a pencil, sometimes it is hypertrophied but pale. Often the trigger point is a hypertrophied follicle just behind the curve of the soft palate, and sometimes it can only be seen when the patient gags or when the posterior pillar is retracted. The patient may refer the tickle to the lower part of the throat and one will find hypertrophy of the lingual tonsil. This may be a large mass of lymphoid tissue extending across the back of the tongue or a few isolated, swollen follicles well down toward the pyriform sinuses. Confirmation that these spots are the trigger areas precipitating the cough can often be made by touching the suspected spot with a probe. The patient then may say "that's the spot" or respond with a typical spasm of coughing.

The treatment of these spots can be with astringents, such as tincture of benzoin, silver nitrate, or cauterizing drugs, applied judiciously to the hypertrophic spots. Much more effective is the use of electrocoagulating current, which destroys these spots. We have never seen complications from this treatment, with the exception of a fairly sore throat and possibly a mild psychic shock when a patient looks at her throat in the mirror and mistakes the slough for pus. Many case histories illustrating this treatment could be reported. One woman said she stopped coughing for the first time in two years after coagulation of these areas. A physician, who had been kept awake by coughing, was treated by this method. Three days later we were horrified to hear that she was hospitalized and in an oxygen tent. When visited she said, "My cough stopped right away. I'm in oxygen because of asthma." It is rare indeed that the

cough is not greatly diminished after this treatment. Sometimes there are other factors involved, such as excessive smoking, allergy, and so forth, and these must be considered. One obese, middle-aged patient had been coughing for years. This was an excellent example of the patient whose cough comes from several causes. His paroxysms were so severe that he said he "blacked out" during them. He was somewhat relieved by coagulation of the pharynx. His membranes were deeply congested during these episodes. When he reduced his cigarettes, the congestion of his pharynx, larynx, and trachea subsided and so did the cough. Smoking is definitely irritating to the membranes in certain individuals and may be an important factor in their cough.

Coagulation is not too comfortable even with cocaine applied topically. We usually have preferred surgical removal of the tissue in children, under general anesthesia. Incidentally, it can hardly be coincidence that so many patients have reported gain in weight, fewer colds, and general improvement in health after this procedure. Probably when the older doctors called this the "rheumatic throat" they recognized its association with the symptoms of focal infection. If we believe that the tonsils may be foci of infection, it is logical to assume that this similar tissue, when infected, acts in the same fashion.

In a large series of these cases, it is interesting to note how many of the patients with the tendency toward recurring hypertrophy of the pharyngeal tissue are definitely allergic. In the allergic patient, this tissue tends to recur even after thorough removal. The other underlying factor in the formation of this tissue is an endocrine disturbance. The throat symptoms and cough which may be so annoying at the menopause are familiar to all practitioners, and we may find hypertrophied lingual or pharyngeal tissue developing at this time. We see it associated frequently with hypothyroidism. In fact, it is amazing how many nose and throat symptoms are caused by hypothyroidism. Dr. Proetz has written several articles on the effect of hypothyroidism on the nasal mucosa and an article on the subject appeared in the *Journal of the American Medical Association,* June 14, 1952. Even minor deficiencies, with metabolic rate of minus 5 or 6 can cause stuffy nose, headache, secretion, recurring respiratory infection, and hypertrophied pharyngeal lymphoid tissue. Proetz discussed these cases as seen in adults, but we have also been impressed by the effect of hypothyroidism in the noses and throats of children.

Our roentgenologist has been alert to this syndrome and reports that he has had at least 30 cases in his private practice in the last two years. Typically, the patient, usually a child, is sent for chest roentgen ray because of cough, which is associated with almost constant colds, and susceptibility to infection. Increased bronchovesicular markings are usually present in the chest roentgenogram. Sinus films taken routinely usually show thickening of the lining membrane. Roentgenograms of the wrists and hands to determine bone age are compared with the patient's chronologic age. If the bone age is significantly less than the patient's actual age, the diagnosis is hypothyroidism. When the pediatrician follows through with administration of thyroid extract, improvement in the entire picture is usually most gratifying. Occasionally a few roentgen ray treatments are given over the chest and sinus areas to hasten the subsidence of the cough.

Before discussing the lower respiratory tract, another cause of the cough reflex should be mentioned; it is not common but may be embarrassing to the practitioner who overlooks it. There is an apocryphal tale among laryngologists of the patient with a cough which resisted all treatment who was finally sent to Arizona. A physician there removed cerumen from the patient's ears and cured his cough. Certainly, stimulation of the auricular branch of the vagus does cause cough, as anyone discovers who has wiped out ears. We have had one child patient whose cough failed to respond to any therapy, and whose diagnostic studies, including chest and sinus roentgen rays, were all normal. When one of us looked into the ears and removed a bead from the external canal, the cough was cured.

Coming to the lower respiratory tract as a source of cough, there is a manifestation of allergy here which is often unrecognized. This is not the wheeze, cough, and dyspnea of asthma, but a rather characteristic dry cough which is referred by the patient to the substernal region, and comes after exposure to an allergen. It does not progress to typical asthma, and does not become productive. It persists as long as the patient is exposed to the allergen. Lacking signs of acute inflammation, allergy must be suspected in these unproductive tickling coughs referred to the trachea. An antihistamine may give symptomatic relief, but elimination of the cause is necessary to cure the cough.

When the chronic cough does not respond to treatment and no upper respiratory cause for it can be found, one must consider bronchoscopic inspection of the lower respiratory tract. In trained hands bronchoscopy is a safe, brief procedure, undoubtedly uncomfortable but usually not painful. It offers the advantages of giving access to the bronchi for

inspection and of permitting removal of secretion. A complete discussion of the value of bronchoscopy is unnecessary here, but in any unexplained or persistent cough, bronchoscopy should be considered.

During bronchoscopy uncontaminated bronchial secretion can be obtained for bacteriologic study and for drug sensitivity tests. This has proved of tremendous value in selecting the optimal therapeutic agent, particularly in children who will not expectorate secretion. In some of our hospitalized children with chronic cough, bronchoscopy is done at least once a week, and each time we take secretion for bacteriologic study and sensitivity tests. This permits us to evaluate the effectiveness of the antibiotic used and to change it if indicated. Also, the therapeutic effect of suctioning out the bronchial secretion is excellent. The resident at one children's hospital remarked with some surprise that a certain baby, receiving intensive medical treatment for her cough, showed her first sign of improvement when we began regular bronchoscopic aspirations.

In examining the tracheobronchial tree of a patient with cough, we frequently send the secretion obtained for preparation of a vaccine. In our bronchoscopic department we are convinced of the efficacy of autogenous vaccine in the treatment of chronic bronchitis. Both in children and in adults, simple, chronic bronchitis or allergic bronchitis has yielded to the use of vaccines made from bronchoscopically obtained secretion too often for it to be mere coincidence.

To quote one case as an example, a child, who had had some cough practically since birth, was seen by a pediatrician when she was 4 years old. He suspected either celiac or fibrocystic disease and treated her accordingly with diet, vitamins, and so forth. At his request, because of the cough and the increased bronchial markings on the chest film, we did a bronchoscopic aspiration and had a vaccine prepared. The vaccine was administered first by the pediatrician, and then when the dose had been established, by the child's father. The pediatrician states positively that as long as the patient gets her vaccine the cough is negligible; when vaccine is stopped or even when the interval is lengthened, it recurs. In this case, the parents, from their observation, are quite as impressed by the effect of the vaccine as is the pediatrician. Seldom, of course, is such prolonged use of vaccine necessary. But in simple, chronic bronchitis or in the asthmatic patient with congested bronchial membranes, a well made autogenous vaccine is good treatment.

If all types of cases where bronchoscopy is helpful in diagnosis and treatment of cough were mentioned, it would cover practically the entire field of chronic chest diseases. This is unnecessary, but a few cases which may be of most importance will be discussed.

In the literature we read about foreign bodies which are overlooked. Foreign bodies in the lung are frequently overlooked as a cause for cough. This happens chiefly because the physician forgets about them. If we train ourselves always to include the foreign body in the list of possibilities when considering a chest lesion, we will not be misled. For in spite of complete lack of foreign body history, the diagnosis is not too difficult with roentgen ray and careful physical examination to help us. We bronchoscopists always hope that some day we will do a routine endoscopy and find an unanticipated bronchial foreign body, but this practically never happens. Preliminary roentgenograms or typical physical findings almost always have suggested its presence before we introduced the tube. A fairly typical case was that of a child who had been coughing for weeks when he was referred to us. At first the cough had been productive, with mucoid secretion which contained blood. The patient even had a history of swallowing a metal fastener, but was treated for bronchitis for about a month before roentgen ray revealed the fastener in the right bronchus. This is fairly typical of the overlooked foreign body; history either negative or ignored, treatment given for bronchitis, pneumonia, or whooping cough, and at long last, diagnosis by roentgen ray, with subsequent referral to the endoscopist for removal of the object.

Bronchoscopy has proven of value in the diagnosis of tuberculous cough in several types of cases. First, in the patient where the roentgenogram is suggestive of tuberculosis but the organisms are not recovered in the sputum to confirm the diagnosis, aspiration of secretion from the bronchus frequently will produce the organisms. This is particularly true in children where sputum is not easily obtained. Bronchoscopy will often show acid-fast organisms when the gastric washings are negative. Also, at the same procedure, inspection of the bronchi may reveal significant changes. Recently we have had a series of cases of infants where the bronchi were distorted by enlarged glands or parts of the lungs were obstructed by caseous secretion and by granulations. These can be definitely diagnosed and treated only through the bronchoscope.

The patient with negative chest film and positive sputum presents another challenge to the diagnostician. Here again direct inspection of the part will sometimes lead to the source of trouble. In one patient we saw last year, the chest film showed nothing significant, yet bronchoscopy revealed an early tracheobronchial tuberculosis, from which we obtained a positive culture.

Another case where bronchoscopy was the key to the diagnosis was that of a patient who had been coughing for three months, and was given a diagnosis of virus pneumonia. Roentgenogram showed increased density in the right lower lobe. Bronchoscopy was done because of the persistent cough which did not respond to treatment. It demonstrated "intense inflammatory reaction in the right lower lobe bronchus, with a moderate amount of purulent secretion." The case was particularly memorable because when the laboratory report showed tuberculosis on smear and later on culture of the bronchial secretion, the entire hospital personnel were angry at having been exposed to tuberculosis without using isolation precautions.

No discussion of cough would be complete without a consideration of carcinoma of the lung. With all our educational crusade, we are still not diagnosing this condition early enough to permit cure in the large majority of cases. We see many cases of carcinoma of the lung, but usually the early symptoms are so unobtrusive that the lesion is far advanced before the bronchoscopist and the chest surgeon are consulted. The lesson here is not to treat cough lightly, not to dismiss it as unimportant, until you have traced its source by roentgen ray, physical examination, and bronchoscopy.

We have had a fairly large number of patients referred for bronchoscopy because routine chest films, taken in surveys or because the patient was a food handler, have shown lesions suggestive of carcinoma. Often symptoms have been absent except for negligible cough. The lesion may be located too far in the periphery to be accessible to visualization through the bronchoscope, but the percentage of correct diagnoses is now much facilitated by Papanicolaou smears from the suspected area. If the patient fails to consult a doctor because he thinks his cough is of no significance there is nothing we can do about it. But if he does consult his physician about his cough, it is our responsibility to investigate thoroughly.

To report one significant case, some years ago, a policeman reported to the department's medical director because of cough. The physical examination was negative; chest film was reported as normal, so he was referred to the chairman of the nose and throat department. Fortunately, the laryngologist who examined him also did the endoscopic examination for the men in the department, so when the nose and throat appeared to be normal, the patient was sent for bronchoscopy. In the left lower lobe bronchus there was a little irregular tissue from which biopsy was done. The report was carcinoma. Here we had an early case, diagnosed through biopsy only because the cough was deemed sufficiently important to require bronchoscopic study.

Often we detect carcinoma of the lung only when the patient has an acute chest condition and fails to respond normally to treatment. Chest roentgenogram is done to check on the progress of the acute lesion and the underlying pathology is revealed. At this phase the lesion is often inoperable.

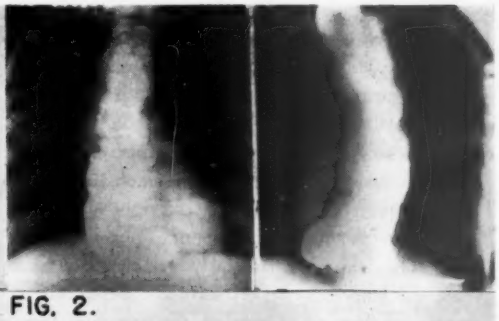
Another type of cough, which is probably more familiar to the endoscopist than to the general practitioner, is the cough of overflow which we find in esophageal lesions. Any obstruction to the esophagus which causes retention of food or of saliva in the esophagus will tend to spill this retained material into the larynx and initiate cough. If this continues for any length of time, an inhalation pneumonitis develops. In fact, in carcinoma of the esophagus, this pneumonitis may be the terminal factor.

We have found that in some patients who have difficulty in swallowing, the cough which occurs from this mechanism is more conspicious and more distressing than the esophageal symptoms. This occurs, for instance, in esophageal diverticulum, where the food first goes into the esophageal pouch and, on change of position, spills into the larynx. It also occurs in cardiospasm, where the whole esophagus dilates until it may hold several quarts of fluid. Naturally when the patient lies down, this fluid regurgitates and causes cough by irritating the larynx and trachea. Sometimes this dilated esophagus makes pressure on the trachea, causing wheezing and other respiratory symptoms. This cough resulting from esophageal lesions was seen in several patients.

The first patient (Fig. 1), a woman aged 56, had intermittent difficulty in swallowing solid foods for one year. About three months before admission, she developed a bad cold with precordial pain, wheezing, and cough productive of a large amount of stringy mucus which often "stuck in her throat." She was treated, she said, "for lung congestion," and the fever subsided but the cough continued. Two months later, roentgenogram of the chest was ordered because of the cough. The roentgenologist also did a swallowing function study and found an esophogeal diverticulum.

The second case (Fig. 2), a clinic patient aged 24, over a period of 17 months had wheezing, coughing, vomiting, and difficulty in swallowing and in breathing. During the time we treated her, she was pregnant, so that complicated the picture also. We found

FIG. 1.



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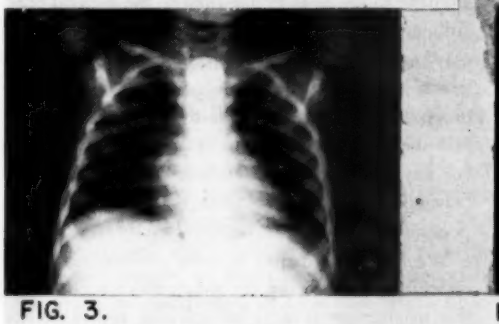

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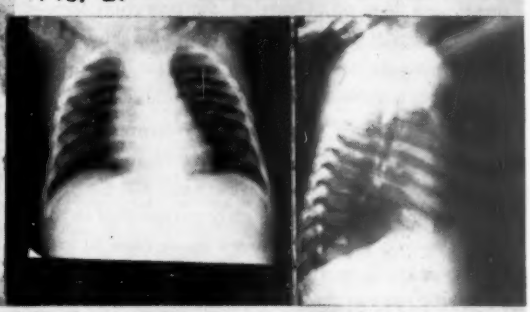

FIG. 4.

nothing significant in the physical examination of her chest, but the roentgen ray revealed the dilated esophagus of cardiospasm. On lying down, the retained food flowed over into the larynx and set up coughing. The cough really bothered her as much or more than the dysphagia and paralleled it closely.

The third patient (Fig. 3), a boy aged 5, had difficulty in swallowing solid food. He also had a cough which was severe enough to cause vomiting, so whooping cough was suspected. During three months' illness, he lost 12 pounds in weight. He was given cough medicines and antibiotics without benefit, as the cough continued unabated. Three months after the onset of his illness, one doctor did a fluoroscopic examination and saw a metal disk in his esophagus. An interesting point here is that the swallowing difficulty was considered secondary to the cough, rather than the primary condition.

The next case (Fig. 4), a 9 month old baby, had had a croupy cough for three weeks. Penicillin and aureomycin had not changed the cough. There were no symptoms of upper respiratory infection and no swallowing difficulty. When the ordinary treatment proved ineffective, the patient was sent to the hospital for chest film and we found a penny located in the esophagus.

In conclusion, some aspects of chronic cough as seen by the otolaryngologist have been presented. Many of them are undoubtedly familiar, some of them may have been forgotten or overlooked, but in reviewing them one often suddenly finds the answer to an unsolved problem.

# Endocrine and Psychosomatic Aspects of Obesity*

Rita S. Finkler, M.D.

THE AVERAGE OBESE PATIENT, distressed and frustrated by her physical appearance, seeks medical advice chiefly because of esthetic and social considerations. She may be aware of the fact that obesity constitutes an actual threat to her health and life expectancy. It has been estimated that in persons between the ages of 45 and 50, overweight of 25 percent increases the mortality rate by 25 percent.[1] It is now well known that many organic diseases are the results of obesity or are greatly aggravated by the presence of obesity, namely: heart diseases, hypertension, atherosclerosis, arthritis, nephritis, diabetes, cirrhosis of the liver, emphysema, varicose veins, and so forth.

## ETIOLOGY OF OBESITY

In self-defense, almost all patients blame glandular disturbances for their obesity. They are encouraged to do so by many physicians who do not make a study of this condition. As a matter of fact, the endocrine disturbances play only a small part in the etiology of obesity. More important factors are:

1. Hypothalamic disturbances with stimulation of the appetite regulating centers.
2. Heredity.
3. Environmental influences, such as putting too much emphasis on food as a chief topic of conversation, concentration on the excellence and abundance of food, and so forth.
4. Parent-child relationship, such as a tendency toward over-protection on the part of the mother which expresses itself in overfeeding the child.
5. Psychogenic factors, especially anxiety, worry, and frustration.

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## ENDOCRINE FACTORS

*Pituitary Hypofunction.* Lowered anterior pituitary gland function is frequently considered to be the etiologic factor in certain types of obesity. It is well known, however, that patients from whom a pituitary tumor or a suprasellar cyst was removed do not show any tendency to gain weight. Atrophy of the anterior pituitary gland, on the contrary, causes cachexia, as seen in Simmonds' disease, in anorexia nervosa, and in Sheehan's syndrome (postpartum destruction of the anterior pituitary gland owing to an infarct).

Many of the so-called "pituitary obesity" cases are actually the result of trauma, infection, or congenital defects in the vegetative centers of the hypothalamus, such as:

1. Postencephalitic syndrome.
2. Fröhlich's syndrome.
3. Adiposogenital syndrome.
4. Psychogenic obesity.
5. Laurence-Moon-Biedl syndrome.

An illustrative case of postencephalitic obesity is hereby presented (Fig. 1).

Case 1. M. W., a white female aged 39, single, height, 61 inches, weight, 429 pounds. At the age of 20, she became ill with encephalitis and was bedridden for one year. Before the onset of illness, her weight was 120 pounds, at the end of the year, when she was able to leave her bed, she weighed 325 pounds, a gain of 205 pounds. She continued to gain until her present weight of 429 pounds.

The attack of encephalitis left her with a definite postencephalitic syndrome: masklike facies, flat monotonous speech, muscle spasticity, right lower facial palsy, positive Babinski's reflex, and a decreased glucose tolerance. There was evidence of diabetes insipidus, as manifested by excessive thirst and fluid intake. She also suffered with menometrorrhagia, and edema and ulceration of the lower extremities. She remained a semi-invalid.

This case illustrates a severe postencephalitic hypothalamic damage. The majority of the hypothalamic type of obesity cases are not so clear-cut as

*These two papers were presented as a part of a symposium on Obesity at the meeting of the New Jersey State Medical Women's Association, held on October 26, 1952, at the Essex House, Newark, New Jersey.

far as etiology or symptomatology is concerned, but, nevertheless, they can be traced to the hypothalamic disturbances.[2]

*Thyroid Hypofunction.* Moderate thyroid underactivity is no longer considered to be an important etiologic factor in obesity. Low basal metabolic rates may be found in pituitary, thyroid, adrenal, or gonadal hypofunction. Low basal metabolic rates may also be found in malnutrition, physical and emotional exhaustion, and in mental depression. More accurate tests for the estimation of thyroid function now employed are estimation of blood protein-bound iodine and radioactive iodine uptake by the thyroid gland. These tests are necessary for the differential diagnosis in doubtful cases. When thyroid failure results in myxedema, the face and upper part of the trunk become edematous and give the impression of obesity. Cases of myxedema are rather rare and an illustrative case is hereby presented (Fig. 2).

Case 2. B. B., aged 54, married, a mother of two children, menopause two and one-half years, complained of being tired and sleepy, numbness of hands and fingers, and of generalized muscle and joint pains. She had gained considerable weight and was told to reduce, because of varicose veins. Her weight was 194.5 pounds, height, 63.5 inches. The face and body appeared edematous. The basal metabolism was minus 27 percent. The blood cholesterol was 214 mg. per 100 cc. and the complete blood count showed moderate secondary anemia. She was placed on an appropriate diet, received thyroid and antianemic therapy, and showed a good clinical improvement with a moderate (10 pounds) loss of weight.

Thyroid therapy is a most valuable therapeutic agent, when clearly indicated. When given indiscriminately it is useless and may cause an inhibition of the patient's own thyroid activity by suppressing the thyrotropic hormone of the anterior pituitary.

*Adrenal Hyperfunction.* The hyperfunction of the adrenal cortex produces a well-known clinical picture, Cushing's syndrome: a buffalo-type obesity, polycythemia, hypertrichosis, hypertension, a decreased glucose tolerance, and osteoporosis.

The obesity is only partly caused by a disturbed fat metabolism. It is chiefly the result of fluid and nitrogen retention and can be corrected partly through dietary adjustments. Correction of the underlying pathologic process (adrenal cortical adenoma or hyperplasia) often produces spectacular changes (Fig. 3).

Case 3. G. R., aged 24, single, height, 62.5 inches, weight, 205 pounds. Her chief complaints were facial hypertrichosis, obesity, headaches, secondary amenorrhea. In the last three years, the patient gained 159 pounds.

Laboratory investigations:

1. Basal metabolism + 18 percent.
2. Glucose tolerance-diabetogenic curve.
3. 17-ketosteroids, 20.7 mg. per 24 hours of urine (normal 14.2 to 15.1 mg.).
4. Roentgen ray of sella turcica, negative.

Perirenal insufflation was planned but not carried out, because of the patient's obesity. An attempt is being made to have the patient lose weight in order to carry out further studies.

*Gonadal Hypofunction.* Diminution or cessation of gonadal function in the female at menopause may cause obesity in some individuals, loss of weight in others, and no change in a third group of persons. Changes in fat distribution (girdle obesity) are more common than a total weight gain.

Diminution in activities and energy expenditure, greater opportunities for relaxation, and leisure to enjoy food may be the responsible factors in those who have a tendency toward obesity during the menopause. In the young, male or female, congenital hypogonadism may tend to produce obesity in the abdominal and trochanteric areas in some individuals; in others no abnormal obesity or changes in fat distribution are noted. The somatic growth is usually on the upper normal levels with eunuchoid measurements (Fig. 4).

Case 4. F. S., aged 28, married, height, 65.75 inches, weight, 165 pounds, menses (primary amenorrhea) were never established. The secondary sex characteristics were poorly developed, small breasts, scanty pubic and axillary hair. The fat distribution was confined to the abdominal and trochanteric regions.

Laboratory investigations:

1. Vaginal smears showed estrogen deficiency.
2. Basal metabolism, complete blood count, and routine urinalysis normal.
3. Blood sugar 124 mg. per 100 cc.

Cyclic menstruation was induced by estrogen therapy.

**Figure 1. M. W., aged 39, height, 61 inches, weight, 429 pounds. Note masklike facial expression, edema, ulceration of lower extremities, and obesity. Figure 2. B. B., aged 54, height, 63.5 inches, weight, 194.5 pounds. Basal metabolism, minus 27 percent, blood cholesterol, 214 mg. per 100 cc. Note facial edema and dull expression. Figure 3. G. R., aged 24, height, 62.5 inches, weight, 205 pounds, 17-ketosteroids, 20.7 mg. per 24 hours. Note obesity, moon-face, hypertrichosis of the face, trunk, and extremities. Figure 4. F. S., aged 28, height, 65.75 inches, weight, 165 pounds. Note eunuchoid body configuration, poor breast development, scanty pubic hair, and girdle obesity.**

Fig. 1

Fig. 2

Fig. 3

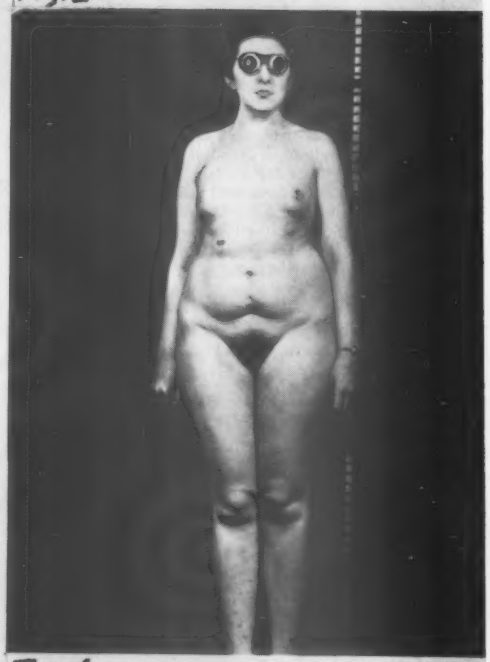

Fig. 4

*Pancreatic Overactivity.* Hyperinsulinism causes hypoglycemia and the subsequent craving to consume carbohydrates and starches. This occurs in pancreatic adenomas, which may be of benign or malignant nature. Certain anxiety states may cause episodes of hyperinsulinism, causing hypoglycemia and excessive craving for food.[3] Obesity is characteristic of many of these patients. Hyperglycemia, however, is a more common finding in the majority of obese individuals.[4]

Consumption of food in excess of body requirements and expenditure is the primary cause of obesity. Excessive amounts of food may be consumed because of habits established in childhood, because of social customs of entertainment, and because of emotional and psychogenic disturbances.

Persons subjected to emotional stress, such as anxiety, worry, and frustrations turn to food for comfort.[5,6] Other persons under similar circumstances will develop an anorexia, which in extreme cases results in cachexia (anorexia nervosa). Rejection of food is a rare occurrence, whereas excessive consumption is common since quick energy yielding foods, the carbohydrates, give the person a temporary sense of well-being.

In individuals with deep emotional disturbances, consumption of food may become an obsession requiring psychotherapy or psychoanalysis.[7] An illustrative case is hereby presented.

Case 5. K. M., aged 24, single, height, 62.75 inches, weight, 168.5 pounds, pulse 84, blood pressure 110/70. Chief complaints: obesity, lack of energy, premenstrual tension, and periods of depression. She had always had a tendency toward obesity and one year ago her weight was 250 pounds. Present weight reduction was achieved by strict dieting, and thyroid and benzedrine® medication. The weight reduction was of short duration, as the patient developed a compulsive trend to overeat to the point that she stayed awake purposely in order to eat. In three months she gained 40 pounds, and when seen again her weight was 207.5 pounds, with prospects of further gain.

A psychologic evaluation, employing standard tests, revealed the patient to be intelligent with an Intelligence Quotient of 125, but of an immature personality. The impression transmitted by a highly qualified psychologist was that compulsive eating was on the basis of avoiding serious adult responsibilities because of obesity.

Laboratory investigations:

1. Basal metabolism, minus 20 percent.
2. Blood cholesterol, 220 mg. per 100 cc.
3. Glucose tolerance, tendency to diabetogenic curve.
4. Complete blood count normal.
5. Blood calcium, 9.0 mg. per 100 cc.

Because of profound exhaustion and periods of depression, a Thorn test was carried out. The result revealed only a slight depression of adrenal cortical response. Attempts at psychologic guidance, and thyroid and benzedrine therapy were of no avail and the patient is now under the care of a psychiatrist.

## Conclusions

1. Endocrine disturbances play a minor role in the etiology of obesity.

2. The so-called "pituitary type" of obesity is caused by disturbances in the hypothalamus on congenital, infectious, traumatic, or emotional bases.

3. Thyroid deficiency with myxedema simulates obesity which is not caused by fat deposits, but is a result of fluid retention.

4. Adrenal cortical hyperactivity, Cushing's syndrome, is a rare disease and may result in abnormal fat deposits.

5. Gonadal deficiency may or may not result in moderate girdle obesity.

6. Habitual excessive food consumption resulting from environmental influences and emotional disturbances is the most frequent etiologic factor in obesity.

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# The Treatment of Obesity

Sylvia F. Becker, M.D.

IN THE PRACTICE OF MEDICINE, the treatment of obesity is somewhat unique. When a patient comes to us seeking ways and means of losing weight, the ultimate success we are going to have depends more on the patient than on the physician. It depends on how well the patient understands his problem and how well he accepts his responsibility.

The first question should be whether the patient is truly motivated to lose weight. Many come to us imbued with enthusiasm and ambition. The lay press has, within the past few years especially, put great stress on the evils of obesity. Certainly patients with diabetes, hypertension, cardiac disease, and arthritis, once they have been enlightened concerning the adverse effects of overweight on their respective diseases, are eager and willing to follow advice aimed at weight reduction. Other overweight people without any obvious diseases, but with poor familial histories, hearing that obesity predisposes to diabetes and hypertension, become excellent candidates for the weight reduction regimen.

Another large group, women mostly, who feel that in their middle years they are losing the attention of their mates, come to the physician's office with a definite motivation. The roving eye of the middle-aged male has sent many a fat and frantic wife scurrying for dietary advice. The younger obese woman, seeing her years slipping by without romantic entanglement, will also follow her physician's advice concerning weight reduction most faithfully, once she has made up her mind to do so.

But everyone who comes to us for the treatment of obesity does not come of his or her own free will. An example is the resentful young adolescent being gently but firmly led in by an obviously domineering mother. Since the basic cause of the obesity in many of these cases is a disturbed familial relationship, and since resentment against the mother is one of the most common factors in this disturbance, the situation is made worse instead of being improved when the child is forced into treatment. Parents are at best a complicating factor in the treatment of children, and when a mother is actually forced to withdraw food from the child, the emotional feelings and the guilt complexes which arise are sometimes too much to bear. Children are also prone to cheating with candy, which is usually obtainable from friends, if not at home, so that treatment of obesity in children, even in good family situations, is a struggle. As stated in the beginning, it is the patient himself who must have the motivation if results are to be achieved.

When first presented with an obese patient, not only should a medical history be taken, but a dietary history must be included as well. It is most simply done by asking the patient to return the following week with a list of foods eaten both at mealtime and between meals. Hidden sources of calories, or irregular eating habits when revealed in this manner are most helpful in guiding the patient. The history should also be complete enough to give a picture of family and work relationships, and any emotional problems which might be pertinent. Of course not all overweight patients are suffering with emotional problems. Some well adjusted people simply enjoy eating for its own sake. Many have acquired the taste for high carbohydrate foods as a result of familial or racial customs of eating. Some basically well adjusted people overeat when beset by temporary tensions, and can be taught to converge their nervous energy into other channels at these trying times.

Many people who are unhappy have fairly obvious problems, and psychotherapy, which often consists only of permitting them to "talk it out," can be handled by the general practitioner or obesity specialist without much difficulty. Some obese patients

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may need the help of a psychiatrist. Examples of this type, aside from the true psychotics, are the people who have an intense desire to put things into their mouths. This group not only includes those who overeat, but also the chain smokers and the alcoholics. Many of these people have had repeated deprivations in their youth, and need psychiatric guidance before they are able to lose weight. Thus the importance of a psychologic and social history should not be underestimated in determining the right approach to each patient's reducing problem.

When the history has been completed, it is essential that a complete physical examination be done, with reference to ruling out any endocrine dyscrasias or any disease process which may be accompanying the obesity. A complete blood count and urinalysis are advisable, as well as other laboratory tests which may be indicated. A small percentage of the cases will actually prove to be endocrine problems. A recent survey showed that less than 3 percent of obesity cases have endocrine dyscrasias.

Treatment in all cases, even if endocrine disease is present, depends mainly on presenting the patient with a diet aimed at decreasing the total food intake to below the energy requirements of the patient. Most authorities recommend that caloric intake be regulated to induce a weight loss of 2 to 3 pounds per week. This may vary from 800 to 1,200 calories depending on the amount of physical activity and energy expended by the patient.

The diet should contain a minimum protein allowance of 1.0 Gm. per Kg. of the normal estimated weight. Proteins are readily utilized, and have the greatest specific dynamic action. Generous amounts of fresh fruits and raw or cooked green vegetables should also be provided. It is advisable to allow green vegetables without limit, so the patients feel they have some free choice.

One must watch the patients for a tendency to omit the protein content in the diet. Protein, unfortunately, is often highly unpalatable to the carbohydrate lover, and in omitting it, he feels he will lose weight faster. Protein, especially meat, is expensive in comparison to other foods, and it is often difficult for patients to purchase the required amounts. The use of cheaper cuts of meat should be encouraged, as well as more frequent inclusion of fish, pot cheese, skimmed milk, and so on.

Care and attention must also be given to impressing the patient with the importance of the proper methods of food preparation. For instance, a boiled egg yields an average of 75 calories, while a fried egg contains 110 calories. Even more impressive, and almost startling, is the fact that a lettuce wedge salad contains only 10 calories, but add only one tablespoon of Russian dressing and it increases to 110 calories. Without thinking about it, many people add bacon fat, chicken fat, and olive oil while preparing foods, literally adding hundreds of hidden calories to their food daily.

Since most people are fond of desserts, and many in being denied them feel that all enjoyment of food has been removed, it is well to allow certain simple desserts such as sherbet, junket, gelatin, and angel food cake. Low caloric beverages, dressings, and sugar substitutes should also be permitted.

An important point about the diet is the definite value of three balanced meals a day, as opposed to the tendency of many people to eliminate breakfast, partake of a skimpy lunch, and eat an enormous dinner. An experiment was done about 12 years ago in which two groups of rats were placed on diets with an identical number of calories daily, the only difference was that one group was fed several small meals, while the other group was fed once a day. Those fed daily with one large meal gained weight much more rapidly than the group fed several smaller meals. The explanation for this phenomenon seems to be that the total metabolism of the body becomes reduced during the long period of no food intake. The animals fed more frequently were more efficiently using the food given to them. Thus, it would seem advisable for the patient to divide his daily caloric allowance as evenly as possible.

Since human will power apparently leaves much to be desired, we have at hand several drugs which aid in suppressing the appetite. The most common ones used are the amphetamine drugs. There are two chemical types of amphetamine, dextrorotatory and levorotatory. The dextrorotatory, commonly known as dexedrine® sulfate, has a distinct depressing effect on the appetite, but the mode of action in the body is unknown as yet. By a reaction through the hypothalamus, there is a delay in the emptying time of the stomach and possibly there is a direct action on the sensory hunger mechanism, causing a satiation at a lower level of food intake. On the other hand, while levo-amphetamine stimulates the central nervous system and has adrenergic side effects, it has absolutely no effect on the appetite. It does, however, sensitize the body to the action of dexedrine sulfate. The drug known as benzedrine® sulfate is a 1:1 mixture of dextro-to levo-amphetamine, and is also known as racemic amphetamine. Other mixtures of the amphetamines have been proposed, the latest being a 1:3 mixture of levo-to dextro-amphetamine, called biphetamine. Another drug being used is

methamphetamine, which is derived from ephedrine rather than benzedrine. This ephedrine derivative is offered under the names of desoxyephedrine, methedrine®, pervitin, or amphedroxyn hydrochloride®, and is similar to dextro-amphetamine sulfate in its reactions.

It is important to select the proper drug for the patient. Dextro-amphetamine is effective only in the type of patient who tends to be somewhat high-strung and has a normal or slightly rapid pulse. Patients with these tendencies have been called the sympathetatonic type, and react quickly and readily to most drugs which are given. On the other hand the patient with the slow pulse, somewhat low blood pressure, and generally sluggish nature derives no benefit from dexedrine or methedrine. These patients require benzedrine or the new drug, biphetamine. The latter has fewer side effects than benzedrine and is therefore more acceptable.

There is one other type of patient to whom none of the aforementioned drugs should be administered. These are the food addicts, similar to narcotic addicts in their reactions. When food is withdrawn from them, they become extremely nervous and apprehensive, the food having acted as a type of crutch. Medication for these patients should consist only of small doses of a sedative, accompanied, of course, by intensive psychotherapy.

Of late, cellulose is used in conjunction with other medications to give the patient the illusion of being filled at a lower level of food intake. This seems to be of value, although cases of intestinal obstruction caused by an overdose of cellulose have been reported. Many types of cellulose tablets and wafers on the market, with an average dose of 1.5 Gm. three times daily, are satisfactory.

Most authorities agree that the only really essential medications to be administered are the multivitamins, since certain hidden requirements may be lacking in a reducing diet, and certainly vitamin A will be deficient. For children and pregnant women, it is also wise to include some form of iron and calcium, and to check carefully on the iodine intake.

Hormones of any kind have absolutely no place in the reducing program of a non-endocrine obese patient. Thyroid has been grossly misused in this respect. According to George Thorn, 75 percent of the people taking thyroid extract do not need it. Small doses of thyroid have no effect whatever on the normal person. Larger doses of thyroid depress the function of the patient's own thyroid gland, and they are then secreting less of their own hormone. They finally have the same amount of circulating hormone that they had in the first place, except that the thyroid is purchased instead of being secreted. This seems to be impractical. Other hormones, such as anterior or posterior pituitary, are completely without value or effect in the treatment of non-endocrine obesity.

When an endocrine problem is actually present, no matter what its source, diet is still a most important part of the treatment program. Dysfunction of the endocrine glands does not add fat to the body; it merely increases the appetite or may cause unusual distributions of fat. Administration of the required hormones alone, without diet, to the obese patient with an endocrine dysfunction will not cause loss of weight. Diet must always be prescribed.

Exercise is a much misused method of reducing. People are mostly fooling themselves when they indulge in exercise or physiotherapy to lose weight. A man weighing 250 pounds would have to climb a 10 foot stair 20 times to rid himself of the energy contained in one slice of bread, or, what is more discouraging, walk 36 horizontal miles to rid himself of one pound of excess fat. Exercise does serve to redistribute the weight and help in re-establishing muscle tone during the weight reduction program. Too much exercise, of course, may serve to increase the appetite.

In some cases of obesity surgery is advisable. After the weight has been stabilized by dietary methods, and fat is left hanging in a pendant apron, removal by plastic surgery is a great relief to the patient, if only to get rid of the underlying dermatitis. Ventral hernias are often present, and repair of these with accompanying removal of large amounts of omental fat is also helpful to the patient. Breast surgery for marked ptosis, which is often made worse after weight loss, is another common surgical procedure.

When the patient has finally been started on the right road, continued weight reduction can only be maintained by frequent and regular visits to the physician, weekly visits if possible. If not seen frequently enough, a weak-willed patient tends to leave his dieting to the few days before his intended visit to the doctor, otherwise ignoring his reducing program entirely. This is all too common an occurrence.

Preservation of morale is the function of the physician, once the diet and medication have been prescribed. There are times, when in spite of strict dieting, weight gain instead of loss may occur. This is caused by an exaggeration on the normal swings of the body water content, and may last for as long as one or two weeks. The patient becomes alarmed and discouraged when he sees this weight gain, but it

should be explained to him as a physiologic occurrence which will be followed soon by a large down swing of the water content.

After the desired weight loss has been achieved, the patient should be told to return at periods of from three to six months for recheck and encouragement. There is great satisfaction for the physician, and certainly for the patient, when a case of this nature has been successful. It results in personal happiness for the patient and is a guarantee of a healthier and longer life.

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# Medical Aspects of Housework*

## ORTHOPEDIC DISABILITIES OF HOUSEWIVES

Edith Lind Kristeller, M.D.

Women have the same orthopedic disabilities as men. To enumerate them would be equivalent to copying the table of contents of a textbook on orthopedics. There are, however, a few diseases which occur more commonly in women than in men. Among these are: congenital dislocation of the hip,[1] and possibly osteoarthritis of the fingers, cervical spine, and knees, although the total incidence of degenerative joint changes appears to be equally distributed between the sexes.[2a] Low back pain due to postural disturbances is said to be more frequent in women than in men,[2b] whereas men show a greater incidence of discogenic backache.[2c] Coccygodynia appears to be a privilege of women[2d] and so also is a fracture of the neck of the femur in the older age group.[3] Rheumatoid arthritis, with the exception of spondylitis, is more often seen in women. Some of these diseases can be correlated to the stress and strain of housework.

The relation between housework and diseases in general, and orthopedic disabilities in particular, is not too well known. The only time-honored occupational disease of housework is housemaid's knee, and this is not seen very often now. No report containing a detailed and statistically valuable study of the subject could be found in the literature. However a few figures are available. Hailman[4] in 1941, reporting on the prevalence of diseases, found that of the people disabled on the day of visit, 0.42 per thousand male workers suffered from orthopedic impairments as compared to 0.32 per thousand of female workers. Both figures were exceeded by 0.87 per thousand for the housewives. This figure, however, cannot be interpreted as meaning that housework causes orthopedic disabilities to such an extent. Only severe impairment had been considered, such as permanent disabilities, congenital malformations, paralysis of any kind, or similar disturbances, and it can be argued that women with such severe impairments may still have a chance as housewives whereas they would not easily be employable in industry. It is also to be noted that the National Health Survey was made by canvassing neighborhoods from house to house, where the housewife would be the usual source of information, and it is to be expected that she would remember her ailments best. In the same survey the prevalence of varicose veins was reported as high as 0.08 per thousand for male and female workers alike, and 0.20 per thousand for housewives.

Another approach to the problem would be to examine the stresses and strains and hazards of housework and to deduce from these findings what kind of orthopedic disabilities might be expected. Ideally such a deduction should be counterchecked with actual figures, but as mentioned before these are not available. The reason for this paucity of information is that housework, except that done by domestic workers, has never come to the attention of large organizations equipped to make statistical studies of medical cases. The housewife is seen by the family physician, whose records are not available for such a study, who sees only a comparatively small number of cases, and who does not have the time to evaluate his cases in that respect himself.

The hazards of housework appear to be rather great. Britten[4] and his co-workers in 1940 reported the figures shown in Tables I and II. The accident rate was higher, the lower the income of any group.

It is interesting to note that up to the age of twenty the accident rate for every type was greater among the men than among the women. Thereafter it changed. This means that as long as men and women spend approximately the same time at home, men have more accidents, but that compared

*The following articles by Dr. Kristeller and Dr. Austin are supplements to the reports on the symposium, "Medical Aspects of Housework," presented at the Council Meeting of the Medical Women's International Association, Vichy, France, September 1952, and published in the* JOURNAL *for February and May 1953.*

TABLE I
Annual Frequency of Home Accidents in Relation to Sex and Employment

| Sex and Employment Status | No. of Cases | Annual Frequency Per 1000 Persons Adjusted Rate | Ratio of Rate to that of Employed Male Workers |
|---|---|---|---|
| Employed male workers | 1,298 | 2.30 | 100 |
| Employed female workers | 684 | 3.90 | 170 |
| Housewives | 2,983 | 5.33 | 232 |

TABLE II
Annual Frequency Comparing Working Females and Housewives as to Age

| Ages | Employed | Housewives | Ratio of Housewives to Employed=x/100 |
|---|---|---|---|
| 15-64 crude rate | 3.27 | 5.92 | 181 |
| adjusted rate | 3.90 | 5.33 | 137 |
| 15-24 | 1.46 | 2.97 | 203 |
| 25-44 | 2.76 | 4.33 | 157 |
| 45-64 | 8.08 | 9.19 | 144 |

with other occupations, work in the house causes more accidents, probably because safety rules are not as strictly observed as in industry. The most common accidents were due to falls; next in line were cuts; then came burns; after that, "all others."

The National Safety Council[5] in 1950 reported the figures shown in Table III.

The most frequent cause of death was falls; thereafter came burns and other injuries associated with fire; mechanical suffocation, the principal cause of death under one year of age; poisons, solid or liquid; poisonous gas; firearms; and after that, "all others." Falls, being the principal causes of injury, are also the most important basis for orthopedic impairments, much more so than any of the other causes, although burns may also cause severe disabilities.

It may be possible to estimate the stresses and strains of housework also by considering the duration of each type of work and by estimating from that the amount of standing, bending, stretching, lifting, pulling, and so on, that the housewife has to do. We admit that this is a crude way of dealing with the problem, but again we have to be satisfied with the little material available. It was possible to get comparative figures from the United States (Table IV) and Sweden (Table V).

Of the activities mentioned, meal preparation and clearing away, care of the house, laundering, buying, and care of the family require much standing, bending, lifting, and stretching, whereas management, sewing, and mending are usually done sitting down. The figures for non-specified activities also include many with similar stresses and strains. For instance, in the figures for the Swedish farm household are included such activities as work in the fields and gardens, which required an average of 35 percent of the daily work in two groups of those studied. Thus the average housewife appears to spend as much as 82.6 percent to 91.3 percent of her working day on her feet, and this working day is as long as nine to twelve hours. We should therefore expect that she would be troubled very much by painful and disabled feet, knees, hips and back,[6] and we can understand why the incidence of varicose veins should be so high. Pains and disabilities of the weight-bearing joints are further aggravated by bad footwear, as is so frequently

TABLE III
Causes of Accidental Death

| Type of Accidents | No. of deaths | No. of non-fatal injuries |
|---|---|---|
| All classes | 91,000 | 9,500,000 |
| Occupational | 13,100 | 1,785,000 |
| Public, excl. of motor vehicles | 15,500 | 1,950,000 |
| Home | 30,900 | 4,650,000 |
| Motor vehicle | 31,500 | 1,100,000 |

TABLE IV

Time Spent on Various Homemaking Activities by 559 Farm and 155 Town and City Families in a Number of States[6]

| Activity | Average Time per Week | | | |
|---|---|---|---|---|
| | Farm Families | | Town and City Families | |
| | Hours | % time | Hours | % time |
| Meal preparation and clearing away | 26.8 | 44 | 22.4 | 35.4 |
| Care of house | 12.8 | 21 | 12.3 | 19.5 |
| Laundering | 6.2 | 10 | 7.0 | 11.1 |
| Sewing and mending | 5.8 | 9.6 | 6.6 | 10.4 |
| Care of members of the family | 4.6 | 7.6 | 8.0 | 12.7 |
| Buying and management | 2.4 | 4.0 | 3.9 | 6.2 |
| All others | 2.3 | 3.8 | 3.0 | 4.7 |
| Total per week | 60.9 | 100 | 63.2 | 100 |

seen in women, by bad posture, and by obesity. The latter does not appear to be more common in women,[9] although some authors appear to think so. The bad posture is not a privilege of women; however, work heights of sinks, stoves and tables, and cabinets arranged either so low that they require constant bending or so high that they can be reached only by a very tall person, are all conducive to special strains and to bad posture in all those people who are not of standard height. Even the standard chair does not always contribute to the woman's comfort, but rather taxes her posture, especially when she has short legs. Pregnancy adds another strain to the weight-bearing joints and in itself is contributory to the development of varicosities. But not only disabilities of the weight-bearing joints are seen. It has been reported from England that many housewives developed a unilateral fibrositis of the shoulder[10] due to the carrying of heavy marketing bags while they were standing in queues for hours during the war. A similar disability is seen in women who do much sewing at the machine in a bad position. Tenosynovitis of the long abductor and short extensor of the thumb is seen frequently in women[11] who have been using the thumb in a repetitive motion over a long period of time. However it is said by other that tenosynovitis and bursitis are fairly uncommon in housewives.[12]

Attempts are being made to decrease the stresses and strains of housework. Schools of home economics as well as such groups as the American Heart Association, the National Tuberculosis Association, and the Disabled Homemakers Research Project of the New York University-Bellevue Medical Center, try to educate women to plan their work better so that less time and effort is required and so that more work can be done sitting down. They try to influence manufacturers of furniture and household appliances to build equipment which is more easily accessible to the average woman and which requires less bending and reaching. The College of Home Economics of Cornell University is experimenting with kitchens that are adjustable to the needs of the individual.[13]

TABLE V

Time Spent on Various Household Activities by 193 Farm and 1,110 Town and City Families in Sweden[7]

| Activity | Average time per day | | | |
|---|---|---|---|---|
| | Farm Families | | Town and City Families | |
| | Hours | % time | Hours | % time |
| Meal preparation and clearing away | 4.53 | 40.2 | 4.07 | 44.9 |
| Care of house | 1.37 | 13.4 | 1.36 | 18.2 |
| Laundering | 0.41 | 5.7 | 0.34 | 6.7 |
| Sewing and mending | 1.55 | 15.6 | 1.31 | 17.4 |
| Care of members of the family | .... | .... | .... | .... |
| Buying and management | 0.21 | 2.9 | 0.49 | 9.3 |
| All others | 4.01 | 2.22 | 1.02 | 3.5 |
| Total hours per day | 12.08 | 100 | 8.59 | 100 |

Further investigation of the incidence of orthopedic disabilities due to housework is necessary. A more detailed comparison between male and female workers and housewives may give us more of the desired information. Such a comparative study may soon be undertaken.

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## THE CARDIAC HOUSEWIFE

**Margaret H. Austin, M.D.**

Limitation of exercise for individuals suffering from heart disease has always been an important part of cardiac therapy, the optimum allowance varying with the heart muscle integrity in each case. Industry has only recently been willing to accept workers handicapped to some degree by rheumatic and arteriosclerotic heart involvement for jobs within their load level. The work devolving upon women who are responsible for keeping their households running has been generally recognized by injunctions to rest more and to take it easy, but up to four years ago no specific attempt was made to analyze the load or to give instruction in any of the work-saving principles long ago adopted in every efficient factory.

Ways and means of lightening kitchen work have attracted women in this country since before the days of candle moulds. Each decade has added 'means,' until today running water, gas or electric heat, and some type of refrigeration are taken for granted in all urban communities. However, no robot has been invented to take the place of the homemaker; even the electric dishwashers, automatic ironers and driers—all the array of expensive time-and laborsaving utilities require human beings to run them.

Ways of easing daily tasks have been worked out by some women who have applied thought and intelligence to them, while others have been content to do things the hard way. When women entered the business and professional fields the necessity for saving time and effort in housework grew, for it is the exceptional working woman who does not at some time have to run a home, and engage in meal preparation, dishwashing, and baby care, in addition to her outside job. Today the high cost of living has driven many more women to take on part- or full-time jobs, while the demand for women in industry has reduced the number available for housekeeping. Even the weekly cleaning woman is difficult to find. It was inevitable that women physicians, having had personal experience in the double role of homekeeper and doctor, should appreciate the load of housework, particularly the load as related to women handicapped by heart disease. From that appreciation grew the first plans for a kitchen modeling work-simplification.

This kitchen, built four years ago by the New York Heart Association, was designed by a woman engineer with the help of physicians, home economists, physical therapists, and architects. The basic principles it supplies are coming into use in other similar kitchens. Why so intelligent an approach to cardiac therapy did not gain immediate and widespread recognition is no more a mystery than is the latent period between the discovery of any scientific fact and its general adoption.

The next kitchen to be built was the one in the Women and Children's Hospital in Chicago in 1951. Approved by the Chicago Heart Association, it was designed as part of a teaching plan to reach that large group of women with heart disease who have the fewest "means" and need the most "ways," namely clinic patients. At about the same time the medical director of the Michigan Heart Association visited the original kitchen in Bellevue Hospital and realized the value of work simplification in the treatment of women cardiac patients. With the cooperation of the director of home economics of Wayne University, a program of teaching for individuals and small groups was set up in the home economics kitchens at Wayne. The publicity given the opening of the Chicago kitchen brought inquiries from all over the country: individuals interested for themselves or an ailing relative, commercial organizations interested in promoting their utilities or gaining ideas for new ones, heart associations wishing to set up kitchens, wrote for information or advice. From Los Angeles to Baltimore, from Buffalo and Milwaukee to Washington State came letters regarding plans, and now scarcely a month goes by but a new kitchen receives the interest and publicity it so well deserves.

Variety is characteristic of these projects. Some are connected with the home economics department of a university, others have part- or full-time home economist consultants. Some of the kitchens are portable to facilitate use in many areas, rural as well as city; some are built by interested utilities under the supervision of local heart associations. The public utilities have been prompt to recognize the importance of this new development of kitchens for handicapped housewives and have been most generous with equipment. Recently the American Medical Association sponsored a program, "Occupation Housewife," which recognized housework as an industry, a point of view which needs no proof for the average woman.

In the mushroom growth of this movement to show women how to save their hearts by easing the housework load, it is easy to lose sight of the basic principles under the beautiful equipment and attractive color schemes in these new kitchens. It should be remembered that relatively few women in our country have the funds to purchase the expensive stoves and cupboards seen in our model kitchens; indeed it is possible that the sight of such affluence can discourage the very ones who need to be taught the ways to use the means they have. We believe: No matter how large or how small your kitchen or the size of your family, you can apply the basic principles of work simplification to your own work space. They are three—

1. Have your work centers close to one another.
2. Adjust your work heights and spaces to fit yourself.
3. Place your tools at the centers where they are most often used.

It has been proved in our classes that women can be taught to think about their kitchens and the work they do in them with these principles in mind, and that many of them gain in energy saved.

There seems to be no limit to the application of this branch of therapeutics. It is being applied to other types of handicapped persons. There are other rooms beyond the kitchen where work-saving can go on. The new kitchens being built in apartments and small homes all over the United States and in Federal housing projects, could just as well be right as wrong if the interest of city planners and architects could be caught. Above all, the movement needs the positive interest and support of physicians who treat women cardiac patients, since they know the importance of effort-saving in the care and prevention of heart disease. Women are quick to see the advantage of these kitchens. The universal reaction is, "If this kitchen is good for a woman with heart trouble why isn't it good for any woman?" Why not, indeed! It might even be good for women doctors!

MEDICAL PRACTICE AROUND THE WORLD

# Physician to the Navajos

WHEN I DECIDED to apply for Indian Service on the Navajo reservation, if I thought about scalping at all, it was with the thought that scalping went out with the advent of white supremacy. Not so some of my friends and acquaintances, many of whom asked, "Do the Indians still practice scalping?" The only such incident that came to my attention was one which occurred in an automobile accident.

I was sent out into the heart of the reservation to be field health and medical officer, with the nearest Government physician and hospital located 78 miles distant, at Fort Defiance, Arizona. It is true that there was a nearer hospital, the well-known Sage Memorial Hospital (Presbyterian Mission) at Ganado, but as it is required that missionary projects be self-supporting, none except the direst emergencies could be dropped off there.

Where the Navajo name originated, no one seems to know definitely. From the spelling and pronunciation it appears Spanish; the tribe calls itself Dineh, meaning "The People." They are very friendly, docile, and stoical. Many of the children do not even blink when the necessary sutures are used in lacerated and incised wounds.

One evening while enjoying dinner with some friends, I was asked to make an emergency call somewhere on Black Mountain where it is alleged there are still some Navajos who have never seen white people. When I inquired concerning the nature of the emergency, I was told that some man had roped and dragged his wife. The story was that the husband had become incensed at his wife, had tied a rope around her, and had dragged her behind him on his horse over the countryside. Accompanying me on this trip were the district supervisor, a Navajo policeman, a social worker (because quite young children were involved), a Navajo practical nurse (who was also to act as interpreter), and relatives of the alleged victim. In the dust and winding roads our car became separated from the rest of the party and we passed the coal mine road by about five miles when we decided we had lost the trail. Eventually we found the others and learned that the entire affair had been a threat, not a reality. What a relief!

Navajo Indians are very responsive to the white doctors' medicine. "The People" travel miles and even days to be present at a field medical or immunization clinic. They come and bring all their relatives. They walk, ride horses, or come in teams drawn by two horses and followed by their colts and dogs, camping overnight along the road. Grandparents and great-grandparents also want typhoid and diphtheria immunization. As co-operative as they are, it is too bad that the shortage of medical personnel drafts doctors suddenly and unexpectedly away from their scheduled trips and immunization clinics, for weeks at a time, thus dropping the routine and lowering the rapport between doctor and patient, and giving the Indians the impression that white people do not care what happens to them.

Among the Navajos, aspirin and penicillin are two proven favorites. Even children expect penicillin shots for everything. One hot Sunday afternoon, while their parents had taken a short trip, a 6 year old boy fell over in a faint; his 10 year old half brother sent for me. After I had diagnosed and treated the heat prostration they both asked whether or not I was going to give the patient a shot of penicillin? An explanation of the proper use of antibiotics left them skeptical.

Many of the Navajos still depend on "sings," held by the native medicine men, highly respected older members in a community. Their religion as well as their medicine has become ambivalent. If the funds are available, a sing is first held for the sick person. This is carried on mostly in the hogan (home), and the leader of the sing is a medicine man. If the progress of the case is not quite satisfactory, the doctor is called in. On the other hand, if the case does not progress to their satisfaction under Government medical care, the medicine man is called in; sometimes the patient is even taken out of the hospital against medical advice. The sings are rather expensive. A series of four is usual, and they may be stretched out over a period not exceeding two years.

The condition of the dirt roads on the reservation and the lack of adequate personnel and facilities add indirectly to the mortality rate. If the roads were better, help might be sought sooner for transportation would take less time. It is not unusual for an obstetric patient to deliver enroute to a hospital because it takes so long for many of the natives to find and obtain transportation, or even to contact Indian service. The distances are very great when one travels on foot or on horseback, especially if a horse must first be found and roped before he is ridden. While I was stationed at the Northern Navajo Indian Hospital, a moribund patient was brought

in at 1:00 p.m. Her first baby had been delivered at 9:00 that morning with only her sister in attendance. She had bled steadily after that. The sisters had had to wait for the return of their father, so that he could ride to the nearest trading post to telephone the nearest missionary for help. How far the missionary traveled to get there was not known. This patient was placed in the back seat of the missionary's car and taken over a road leading by devious windings throughout the southeastern portion of Utah, to southwestern Colorado, across the corner of that state, and down into the northwestern part of New Mexico, to our hospital at Shiprock. The patient died about twenty minutes after arrival, despite heroic shock treatment and other first aid efforts.

Chauffeurs are not available for doctors, only for nurses. Men physicians are stationed at hospitals, and house calls for them are rare occurrences. Needless to say, one learns to change flats and make some motor repairs. But changing flats and performing first aid or delivering babies on the same trip, without adequate facilities for aseptic technique, can be dangerous. I was very lucky. A chauffeur also helps as a guide and interpreter in making field trips and home calls. It is very difficult to reach a strange place and to obtain information there when one is unable to speak or even understand the language.

There are many accidental abortions, some only threatened, but many inevitable. During my first month, in taking histories, I asked if unusual or heavy labor had occurred just prior to the onset of pains or bleeding. At first none was mentioned; and the reason for this was that the patients had been carrying out only their routine womanly duties of chopping wood, hauling water, and herding flocks of sheep up and down hill. The only one of the reasons that was actually mentioned was the carrying of bundles of snow. Later in the office, I asked the interpreter what this was for. What was the purpose of carrying bundles of snow? Was snow so rare? Then I learned that carrying bundles of snow a mile was preferable to trudging on foot or by team to the nearest well or water hole. And water holes they are. Inspected wells are scattered over the reservation at an average of 5 mile intervals, although some are farther apart. If water can be obtained from a rock or basin, or by digging down in the sand of a dry wash, this water is used, even if birds and coyotes use the same water hole for drinking and bathing.

Working among the Navajo Indians was a varied and most interesting experience. The area to be covered is so huge, the medical facilities so limited, travel so hazardous, that even routine tasks demand extra time and energy. More help is acutely needed, and the Navajos on the reservation are a problem to which America should devote particular thought.

PEARL E. HACKMAN, M.D.

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## HEALTH IS WEALTH

*Money spent on health is money saved on disease.* From 1929 to 1939, the city of New York carried out an energetic campaign against diphtheria, spent $500,000 and brought down the number of deaths caused each year by this disease from 1,000 to 22. Previously in one year (1920) New York had spent $1,027,000 on treatment of persons suffering from diphtheria. Thus, more than twice as much was spent in one year to treat a disease as in ten years to prevent the same disease. This comparison is all the more striking because prevention of the disease not only proved much less costly, but was also extremely effective.

*Disease is a crushing burden on the national economy.* In the Philippines, in regions where malaria control demonstrations have been carried out, absenteeism in the schools fell from 40 percent in 1946 to 3 percent in 1949. Following mass treatment of the disease, it has been found that the same work can be done with 20 percent to 25 percent less man-can be done with 20 to 25 percent less manpower.

*Prevention is better than cure, and much cheaper.* The cost price of a disease drops considerably when treatment is accompanied by a mass campaign of prevention. Thus Greece, which once was among the world's greatest quinine consumers and used to spend $1,300,000 every year to procure this drug, today has an outlay of only $300,000 per year for DDT with which to combat the direct causes of malaria. Result: for 2,000,000 persons suffering from malaria in 1942 there were 50,000 in 1950.

*Health and prosperity are inseparably linked together.* Health is capital that brings in returns. Wherever energetic action has been taken with adequate means, sickness and death rates fall and it becomes possible to foresee and improvement in economic conditions. For example, as a result of the Haiti Government's action against yaws, 100,000 people were able to return to work, increasing the country's output by $5,000,000 per year.

(United Nations, WHO, April 2, 1953)

# World Health Organization

## PROBLEMS OF CONTROLLING INFLUENZA

SOME OF THE PROBLEMS involved in attempts to control influenza, the World Health Organization's efforts to find solutions, and prospects for future progress against the disease are outlined in an article "Influenza Today," prepared by Dr. A. M. M. Payne, a member of WHO's Division of Communicable Disease Services.

Dr. Payne reports in his article: influenza is news. Each time an influenza epidemic appears on any large scale, and this happens every two or three years, frequent reports in the press reflect public interest and anxiety. Memory of the 1918-1919 pandemic dies hard, and it is right that it should live since we do not know what combination of circumstances brought it about, nor whether it will ever occur again. Nevertheless no subsequent epidemic has been on such a scale or of such severity as to justify comparison with that disaster. And yet the comparison has been made in some reports even in this year's mild epidemic, whereas other reports have contained too optimistic views on the prospects for controlling the disease.

Unfortunately vaccination against influenza produces neither as lasting nor as complete immunity as does, for example, vaccination against smallpox. In controlled trials in the past the unprotected individuals have been attacked about four times as often as the inoculated, but a number of the latter still become ill with the disease, and the degree of protection has probably waned considerably after a year. It must be stressed that the vaccines at present under test lend no hope of being able to eliminate the disease; the best that can be hoped for is to limit the effects of an epidemic by reducing the number of people who fall sick and hence diminishing the economic effects of the epidemic which are sometimes serious.

All claims of the successful control of influenza must be interpreted in this strictly limited sense. If by control measures the effect of an epidemic of influenza could be reduced throughout a country to one tenth of what it would otherwise be, that would indeed be a success. It cannot be achieved at present. There are several difficult problems which must be solved first.

Primarily there is the unpredictability of the influenza virus, which shows no stability in nature. This is being tackled, as already explained, by an "intelligence service" in the shape of the WHO network of laboratories which is constantly studying changes in the virus as they appear, and this, it is hoped, may eventually lead to the ability to forecast epidemics with reasonable reliability.

Further, a great deal remains to be learned about the best methods of producing, testing, and using vaccines. There is, for example, a relatively new type of vaccine under test which appears to have advantages in the degree and duration of immunity produced, together with economy in the amount of virus needed. There is no doubt that if this is confirmed and the safety of the vaccine proved it will represent a major advance; however, at the present time it must be considered experimental.

The use of influenza vaccines presents a number of problems. It is clearly impracticable to vaccinate the whole population each year owing to the great expense and difficulties of such a scheme. The questions are whom to inoculate and when. The answers will depend a great deal on local conditions and economy. It is hoped that some guidance on this will be forthcoming as a result of the trials at present in progress.

An important function of all health authorities is the protection of the public from dangerous, inferior or inactive products. To effect this it is necessary to lay down tests and standards to which products must conform. Although this has been done in some countries, there are, as yet, no universally agreed standards for influenza vaccine which are needed before it can take its place as a fully recognized preventive agent.

To sum up it may be stated that there is good reason to believe that influenza vaccines will play a principal role in lessening the effects of influenza epidemics in the future. However, they give no hope of eliminating influenza altogether, and indeed further research and careful observations are needed before the best methods of preparation and use of vaccines can be decided.

Nevertheless a great deal of research work is in progress and it may be hoped that solutions to many problems will be found in the not-far-distant future.

# American Medical Women's Association

## PRESIDENT'S MESSAGE

ONCE AGAIN a new Board of Directors and a new President greet each member of the American Medical Women's Association. We thank you for honoring us in this way and hope that your confidence in us will prove justified.

Our retiring President, Dr. Evangeline Stenhouse, has been most thoughtful in keeping me informed concerning the business of our organization. Her helpful suggestions will make it easier to achieve continuity of action in projects already initiated.

As your President, I shall continue to emphasize: "The object of this organization is to bring medical women into association with each other for their mutual advantage; to encourage social and co-operative relations within and without the profession; to further such constructive movements as relief work and public health; to aid women medical students; and to assist women physicians in postgraduate work."

We have much to give that is of enduring value. During a recent trip to Greece and Turkey I was greatly impressed with the far-reaching importance of one of our Committees, Medical Service (American Women's Hospitals), in promoting friendship and understanding. This Committee helps the little people, the people who make up most of the world. They sincerely appreciate the help we are giving, not as rich benefactors, but as other little people from a great democratic country who are willing to share and thus work for the hope of the world . . . peace.

Many important Committees such as Scholarship, Publications, Historical, Library, Public Health, and others offer each member of our organization an opportunity to take part in some project that appeals to her particular interest. Since the President cannot know the different preferences, may I ask that you write to me at once stating your choice. We have no overproduction!

Judith Ahlem

# Opportunities For Women in Medicine

## MEDICAL RESEARCH

**Jeanne C. Bateman, M.D.**

THE WAR AGAINST DISEASE is repeatedly spotlighted by drives for financial aid in combating cancer, heart disease, tuberculosis, poliomyelitis, rheumatic diseases, diabetes, multiple sclerosis, and others. On a local level, hospitals and clinics ask public support, both tax funds and voluntary gifts, to enable them to use the newest and best treatments in caring for their patients. No other era has known such a consuming public interest in the ills of the human body and in the development of new drugs and forms of therapy; lay magazines, the radio, and television intensify this preoccupation with health and the problems of illness. And behind all of this progress and publicity is the research worker—chemist, biologist, physiologist, physician, physicist, statistician, laboratory technician, and aide.

All research follows a general pattern before it is translated into a weapon against disease. With many groups of people working on various phases of the problem, the workers themselves find it difficult to envision the over-all concept of the many aspects of investigation that go into the development of new products or methods and the improvement of those already considered standard. Therefore, we have attempted a brief outline of the steps that medical research must take. These are not always followed in logical order, however, for not infrequently a start is made in the middle of a problem, with more basic research to follow at a later time.

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### THE CLUE

Ideas for new research come from many sources. A pertinent observation of a laboratory phenomenon may give the clue. Study of observations made by other scientists may suggest different or more extended application of such knowledge. Simple clinical observations of patients' reactions may suggest a new method. Development of compounds closely related to an agent already proven may increase the effectiveness of that agent or reduce its toxicity. Even errors may suggest new research.

The story of penicillin began when an inquisitive scientific mind observed that a colony of mold on a contaminated plate of culture media prevented the growth of bacteria surrounding it. But the story of its ultimate development for use against previously lethal pneumonia, meningitis, and other serious infectious diseases could not unfold until incredible quantities of painstaking scientific work had been accomplished.

How is it possible to translate a simple observation into a potent weapon against disease? Having observed a phenomenon and questioned its possibilities, the scientist sets out to investigate its mechanism. His task is to study its harmful properties, to increase its useful potentialities, and to develop it as an agent of healing.

### BASIC RESEARCH

This is the study which precedes the application of a new drug or method of treatment of human illness. It proceeds at various levels.

*Subviable level.* Work at this level includes purification of chemical compounds and extraction of active principles from therapeutic agents in order to increase potency. Drugs which have serious side effects must be altered to decrease toxicity. The characteristics and actions of enzymes and hormones need to be elucidated. Basic research may involve

perfection of mechanical means of treating disease by building elaborate pieces of apparatus such as the mechanical kidney and heart. Or far simpler is the development of a syringe calculated to deliver an accurately measured amount of drug into a blood vessel in a given time, or the development of a special instrument such as a valvulotome which cuts the stenotic valves in a heart.

*Viral and bacterial level.* Studies of these low forms of life are of inestimable value. Some of these particles produce swift death, others are harmless, and still others are indispensable. We now know that bacteria in the intestines are related to the production of certain vitamins. Some bacteria restrain the growth of others. There are viruses that apparently live happily in our bodies and manifest themselves only sporadically in such ways as "cold sores." In animals and fowl, some viruses are intimately related to certain cancers. Because bacteria need specific nutrients in their media, investigations along this line have been of tremendous importance in the study of vitamins and agents which block the action of vitamins.

*Cellular level.* A brilliant field of study was opened by the development of tissue culture techniques. Not only can multiplying normal cells be observed but also diseased or cancer cells. It is possible to observe the effects of drugs and hormones directly on this growing, multiplying tissue. It can be determined how much of an agent will kill the cell outright, how much will leave it unaffected, and how much is needed to slow or to stimulate cell division and the phase of cell division which is affected. Observation that antibiotics in certain amounts slow cell division prompted the use of these agents in small animal tumors and, more recently, in human cancer.

Cells removed from various body orifices and studied according to some of the newer cytologic techniques may reveal the presence of cancer as well as the effect of hormones and drugs on the body. Histochemical studies are adding to our knowledge of the chemical nature of protoplasm.

*Plant studies.* Plants suffer from viral, bacterial, and metabolic disorders. They may, therefore, serve as testing grounds for some agents potentially useful in the treatment of human disease. For example, the observation that aureomycin inhibits division of onion root tip cells at a certain concentration inspired investigation as to the range of concentration which may be needed to arrest cancer cell division.

*Animal studies.* The usefulness of animals in medical research has long been appreciated and has increased since cancer research has progressed. Their value in the latter is particularly understandable when the universality of cancer is considered. Animals have cancer just as humans do. Leukemia occurs in horses, cattle, cats, dogs, rats, mice, and even in chickens. Obviously, as better treatment for people is developed, better care for sick pets also becomes available.

Mice are invaluable in research because large numbers can be housed in a small area, they are relatively inexpensive, and their fairly short period of growth and of life span permits observations on growth and hereditary factors.

When new drugs, treatment methods, or surgical techniques appear to have promise, it is then desirable to test them on larger animals such as rabbits, pigs, dogs, and monkeys. Species variability must be a primary consideration since some species of animals are resistant to certain disease agents. Drug toxicity is variable from species to species and, in mice at least, from strain to strain.

## Clinical Research

When a method or drug has passed all of the rigid scrutiny of chemical investigation, bacterial study, tissue culture, and animal study, it is still not ready for general use in the fight against human disease.

The human species has its own special reaction to drugs and environment. Clinical research is carried out on two groups of people. First the healthy volunteer, including laboratory workers, medical students, and doctors on whom methods and drugs are tested. With this group it is possible to learn the general action of a drug but not its effect on a particular disease.

For the latter it is necessary to turn to the sick patient. In cancer and in other diseases there is no justification for experimental treatment of patients who may be expected to improve under a standard form of therapy. For this reason it is the hopelessly ill who first receive the benefit of new forms of therapy. As knowledge increases regarding the limitations as well as the advantages of such therapy it can be applied to patients with less advanced disease. The fact that the first trials are thus so limited in scope is a handicap which is unavoidable; although progress is slowed in some ways, certain abuses are prevented.

## The Research Doctor

A career in clinical research should be well founded on a knowledge of the methods and drugs to be used, as well as with a thorough understanding of the natural course of the disease to be studied and the standard forms of therapy presently available. The doctor doing research must be constantly on guard against unexpected good and bad effects. He must make countless measurements and observations. He must know what other research workers throughout the world are learning about this particular disease, always alert to correlate other observations with his own. And above all, since he is a physician first and last, he must take the best possible care of the patient, controlling pain if possible, maintaining nutrition, watching for and treating complications, and giving the encouragement and sympathy that are such essential components of medical care.

In each newly graduated group of medical students a few will be imbued with an irresistible urge to "do research." This may result from natural curiosity or from association with other workers in the field. Still other students may inadvertently take the first step in this direction by accepting a research fellowship which, though modestly remunerative, offers a temporary but expedient form of security while, at the same time, prolonging the stimulating experience afforded by a research-minded medical school or institution.

Whether research is carried on at the basic or clinic level, there are certain needs to be met. Space is essential, but sumptuous surroundings are not necessary to sound research. A few square feet of space and a bench in a laboratory may fill the need. Equipment is also necessary. Research grants frequently make provision for a certain amount of equipment and materials. If the problem to be studied involves animal work, adequate housing and care for them must be available. If the problem is clinical in nature, a source of proper patient material is essential.

Special training or knowledge in such fields as chemistry, physiology, and pharmacology augment the research worker's ability. Without a working knowledge of laboratory tests and methods the individual may not realize the limitations of such tests. Unless he is fortunate enough to have at his disposal technicians of unusual integrity, he can rely only on work performed by himself.

The young research worker can apply for any one of the innumerable fellowships offered by universities, various foundations, pharmaceutical companies, and certain agencies in the government. Many of these are listed in a publication entitled "Fellowships, Funds and Prizes" compiled by the Association of American Medical Colleges at 5 Wabash Ave., Chicago, Illinois. The applicant describes the research which he plans to do and he provides information as to his training experience, work situation, and facilities available. An age limit is designated in some instances. Most of the fellowships are intended to aid young men and women of promise in scientific research to gain background and training for special fields in medicine. The stipend offered is modest; a travel fund may be available and frequently there is limited allowance for equipment. The fellowships are usually granted for a one year period; some may be renewed. This limitation in time is one of the serious handicaps of research today. Unless the research worker is under the guidance of an experienced person or is unusually lucky, he will find that by the time his equipment is collected, his methods set up, and his contacts established, the time allotted for his research will have been largely dissipated. Since the majority of these individuals will not continue in research, it may seem more intelligent for the young doctor to start immediately in medical practice or in a specialty. This is especially true when one considers the length of medical training as compared to training for other professions.

It has been stated that no one should anticipate staying in research for more than three to five years because there is difficulty in obtaining financial support after this time. Certainly the opportunities for making medical research a lifetime occupation are extremely limited considering the short-term nature of most of the available fellowships.

The National Institutes of Health offers opportunity for career research. There are now 10 women in this agency; 8 are under Civil Service status and 2 have semi-military status. In the metropolitan area of Washington, D.C., there are 162 men in this agency; 140 are commissioned officers in Public Health Service and 22 are under Civil Service. Practically all are engaged in research.

A large portion of medical research is done at medical schools by individuals holding teaching positions. The combination of teaching and research is often desirable. However, in order to continue research these individuals must carry a share of the school's teaching load. This as well as administrative duties may sharply curtail time available for research activities. Pharmaceutical companies have forwarded medical research both by a vast amount

of basic research in their own laboratories and by generous grants of money and supplies to various institutions.

One might speculate on the waste of training and money involved in giving research aid to large numbers of young people, so few of whom can continue with the work. It may be argued that the gifted will find a place. We cannot agree with this. The factors which are most potent in developing an adequate research staff are unquenchable curiosity, hard work, and training. Although genius can no doubt contribute much to research, the cold fact remains that the heavy burden of work which produces soundly tested results rests on the painstaking and often poorly rewarded scientist.

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## AWARDS AND CONTESTS

*Special Training Awards in the National Heart Institute.* Fifteen young physicians have recently been given special training awards under the clinical traineeship program of the National Heart Institute. A total of 32 physicians are now receiving heart traineeships, studying in 25 institutions in 12 states and the District of Columbia. Since the inception of the program 4 years ago, 149 physicians have been given the opportunity to acquire special skills in diagnosing and treating the heart diseases which afflict about nine million people in the United States. The majority of these doctors have completed their periods of study and are helping to relieve the serious shortage of physicians who understand techniques of interpreting electrocardiograms, carrying out cardiac fluoroscopy, and correlating various diagnostic findings.

Traineeships carry stipends of $3,000 per year for trainees without dependents and $3,600 for those with dependents. Eligible for such special study are doctors who are citizens, who have completed a general internship, have at least one additional year of experience or training, and are not over 40 years of age. Applications for the traineeships may be obtained from the National Heart Institute, Public Health Service, Bethesda 14, Maryland.

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The National Safety Council has announced the 1953 Carol Lane Award program. The new feature, added this year, is the opportunity for a woman's club or similar organization to achieve national recognition for a group effort in traffic safety promotion. There will be equal awards in both categories: a top award of a $1,000 Defense Bond plus a bronze sculpture, and three honorable mention awards consisting of plaques of the sculpture. All eight award winners will be invited to the presentation during the National Safety Congress in October.

Will any members of the AMWA who have participated in traffic safety programs please contact the Committee on Opportunities for further details. Full information may also be obtained from Alice C. Mills, Director of Women's Activities, National Safety Council, 425 N. Michigan Ave., Chicago 11, Illinois.

*Endocrinology Awards.* The Ciba award, given in recognition of the meritorious accomplishments of an investigator, not over 35 years old, in the field of clinical or preclinical endocrinology, has been increased from the original $1,200 to $1,800.

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The American Committee on Maternal Welfare, Inc., is sponsoring a contest for original research on the so-called toxemias of pregnancy. It is open to students and personnel in health professions who are not of higher rank than instructor, or who are of junior rank on hospital or other staffs. Two cash prizes of $500 and $250 will be awarded. Entries must be submitted no later than January 1, 1954. Address: The American Committee on Maternal Welfare, Inc., 116 S. Michigan Ave., Chicago 3, Illinois.

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## AMERICAN AID TO AUSTRALIAN SCHOLARS

United States Ambassador Pete Jarman has announced in Canberra that the U.S. Government will make dollar funds available under the U.S. Information and Educational Exchange Act, 1948 (Smith-Mundt Act), to assist Australian research scholars and lecturers to pursue advanced research or lecturing at American universities during the academic year 1953-1954.

These opportunities are being offered in conjunction with travel grants under the Fulbright program. Selected candidates will receive a dollar grant under the Smith-Mundt Act to assist them to meet living costs while on research or lecturing projects

in the U.S., and, in addition, they will be awarded a Fulbright travel grant to meet transportation expenses between Australia and the U.S. The U.S. dollar assistance will be $9 a day for periods varying from 3 to 10 months, depending upon the dollar funds available to candidates from other sources.

### PROGRAM FOR MIDSOUTH PHYSICIANS

The University of Tennessee Medical Unit's Postgraduate Department has scheduled a course in primary treatment of trauma (simple injury) for July 15, 16, and 17. This course will be presented at John Gaston Hospital, teaching facility of the College of Medicine, under the direction of Dr. Harwell Wilson, chief of the division of surgery.

The course will consist of lectures and demonstrations by members of the staff of the College of Medicine. For further information write University of Tennessee Postgraduate Department, 4 South Dunlap, Memphis, Tenn.

### RESIDENCY

The University of North Carolina announces an associated psychiatric training program, to begin July 1. The residency training program will consist, as a minimum, of a logical progression through a three year training period to meet the requirements of the American Board of Psychiatry and Neurology in psychiatry. Stipends are, first year $3,000, second year $3,500, third year $5,000. The program is directed by Dr. George C. Ham, professor and chairman, department of psychiatry, and by Dr. David A. Young, superintendent of State Hospitals' Board of Control and clinical professor of psychiatry in the medical school, Chapel Hill, N. C.

### OFFICE SPACE FOR LEASE

Two modern suites for physicians. New garden apartments. Ideal location in Ridgewood, New Jersey, finest of suburban communities. Each suite ideal for one or two practitioners. Immediate occupancy. Inquire Geo. H. Beckmann, Inc., Realtors (Established 1924), 46 Godwin Ave., Ridgewood, N. J., Phone 6-8323.

## OPPORTUNITIES WANTED

### APPOINTMENT IN SURGERY

Thoracic and General Surgeon. Woman. M.D., M.S. (Surgery). Practical, teaching, and research experience. Interested in U.S. or foreign location. Please include particulars in reply. Box 5343, J.A.M.W.A., 1790 Broadway, New York 19, N.Y.

## NEW MEMBERS

### ASSOCIATE

**Catharina A. A. Bramlage, M.D.**—Alexandria Hospital, Alexandria, Va.

**Ebba Kuldvere, M.D.**—Mary's Help Hospital, 145 Guerrero St., San Francisco, Calif.

**Taissia Reinhardt, M.D.**—203 So. Lorraine, Wichita 8, Kan.

**Leola Steiner, M.D.**—5319 Monlaco Rd., Long Beach, Calif.

**Ceila Suso, M.D.**—100 Richland Ave., San Francisco, Calif.

**Lillian Wong, M.D.**—1224 Hyde, San Francisco, Calif.

### JUNIOR

**Miriam H. Bernstein** — 1901 East-West Highway, Apt. 203, Silver Spring, Md.

**Dorothy S. Dobbs** — 8302 Roanoke Ave., Apt. 3, Takoma Park, Md.

**Virginia A. Duggins**—2354 N. Quincy St., Arlington, Va.

**Jo Ann Mary Hein**—1488 Belmont Ave., Columbus 1, Ohio.

**Inez Lorraine Ice**—5125 Georgia Ave., N.W., Washington, D.C.

**Margaret L. Lambert**—625 N. Emerson St., Arlington, Va.

**Sarah Pamelia Leech**—5 Curtis Court, Chevy Chase 15, Md.

**Kathryn A. Williams**—625 No. Emerson St., Arlington, Va.

## NEWS FROM THE BRANCHES

### Branch Two, Chicago, Illinois

The annual meeting of Branch Two was held on May 13, 1953, with a reception and dinner, and included committee reports and installation of officers.

Officers for 1953-1954 are as follows: Dr. M. Alice Phillips, *President;* Dr. Clementine Frankowski, *President-Elect;* Dr. Marguerite Olive, *First Vice-President;* Dr. Catherine Dobson, *Second Vice-President;* Dr. Elizabeth McGrew, *Corresponding Secretary;* Dr. Ella Sandberg, *Recording Secretary;* Dr. M. Jean McBean, *Treasurer;* and Dr. Clara Gottschalk, *Assistant Treasurer.*

# CATHERINE CHISHOLM, C.B.E.

## M.D. (Manchester), Hon. F.R.C.P.*

An event which has given much pleasure to medical women was the naming of a ward in the Duchess of York Hospital for Babies, Manchester, Lancashire, England, for Dr. Catherine Chisholm. This ward was opened in June 1952. Dr. Chisholm, aided by a group of influential Manchester men and women, founded this hospital in a small house in a Manchester suburb in 1914, just before the outbreak of World War I. It has become one of the best known pediatric hospitals and is especially famous for its care of the premature infant.

Catherine Chisholm is of Highland Scots descent. She was the first woman to enter and, in 1904, to graduate from the Manchester University School of Medicine. She was one of the first two women to receive a medical degree from Manchester, and was the first woman general practitioner in the large industrial city of Manchester. For half a century her name has been a household word in all matters concerning the health and physical welfare of women and children in the South Lancashire area.

After a period of general practice, Dr. Chisholm specialized in the diseases of infants and children. To learn the pediatric methods of another country, she came to the United States for postgraduate study. Her long association with the Manchester High School for Girls enabled her to write a thesis on menstruation in adolescent girls. This monograph was immediately recognized as an important contribution to this phase of medicine.

Dr. Catherine has always been a friend and adviser to young medical women and students. She has found time, too, to play a part in civic affairs, and to be a founder of the British Medical Women's Federation. From 1928 to 1929 she was president of this group. She is also a founder member of the Federation of University Women.

Dr. Chisholm has been pediatric consultant in three leading hospitals; one of these was the Duchess of York Hospital for Babies, which she helped to found. Until recently she was its honorary physician and guiding spirit. She has also been a lecturer in pediatrics at the University of Manchester.

She has worked with great zeal to improve the status of women through extension of suffrage and the rights of married women to work. In 1935 her fine medical and public work was recognized by the award of the C.B.E. In 1947 she received the rare honor of an honorary fellowship in the Royal College of Physicians.

At 74, Dr. Catherine Chisholm can look back on her life and achievements with legitimate pride and satisfaction.

Marcelle Bernard, M.D.

*University Women's Review (England) May '52.

# News of Women in Medicine

## BLACKWELL AWARDS OF THE NEW YORK INFIRMARY

ELIZABETH BLACKWELL CITATIONS awarded annually by the New York Infirmary to five women for distinguished service in the field of medicine were presented recently in a ceremony in the auditorium of the Manhattan General Hospital, which is host to the Infirmary while its new hospital is being built on Stuyvesant Square.

The 1953 awards were made to Dr. Alice Hamilton for her pioneer work in industrial medicine; Dr. Josephine B. Neal for her work in research and in control of communicable disease; Dr. Ellen C. Potter for achievement in the field of public health and welfare; Dr. Florence R. Sabin for her leadership in medical research and public health; and Dr. Ida S. Scudder for brilliant achievement in medical missionary fields.

These awards, established five years ago, are given annually in celebration of Elizabeth Blackwell's graduation from the Geneva Medical School in January 1849, the first woman to receive a medical degree in modern times. The New York Infirmary, which presents the awards, continues the fundamental policy laid down by Dr. Blackwell, to open the doors of medical education, development, and service to women and to give medical care to those unable to pay.

Dr. Leona Baumgartner, Assistant Commissioner in charge of maternal and child health services of the Department of Health of New York City, was the principal speaker. Dr. Baumgartner received the Elizabeth Blackwell Citation in 1950 in recognition of her public health services for children. She paid tribute to "the devoted and courageous pioneering" of the five women receiving the award who have "lived long enough to see many of the extravagant dreams of their youth come true" in improved social conditions, in the doubling of the life span, and in the putting into practice of many important medical discoveries.

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ALICE HAMILTON, M.D., D.Sc.

The New York Infirmary makes this citation of Dr. Alice Hamilton in recognition of her unique contribution to the development of industrial medicine and to the welfare of the working people of America. From a protected and cultured environment Alice Hamilton sought a medical career to increase her knowledge of the world and its people. Using her scientific training as a tool, she sought and attained broad social goals far beyond the realms of medicine. When she started her work industrial poisons were taking a huge toll among our workers. Industrial medicine as we know it today did not exist in America, and industrial hazards were not recognized as a responsibility of the employer. As a result of her crusading zeal and her pioneering studies of the dangerous trades, the eyes of business men, legislators, and physicians were opened. Long before her efforts stimulated the necessary corrective legislation she had persuaded top executives of many factories, mines, quarries, and smelters from coast to coast to make their plants safe for their workmen. She needed no authority other than the strength of her evidence, the force of her dedicated personality, and the quiet charm of her manner. In the short space of this one woman's career, health conditions in industrial plants have been revolutionized, workmen's compensation laws have become almost universal, and industrial medicine has been recognized as an essential scientific specialty. She was the first woman appointed to the faculty of Harvard University, where for fifteen years as professor of industrial medicine in the medical school she trained many other leaders in that field. No single individual in the United States has had greater influence on the health of our industrial laborers than Alice Hamilton. The New York Infirmary is proud to confer the Elizabeth Blackwell Award on Dr. Alice Hamilton, as the founder of industrial medicine in this country, and as one of the great women of America.

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The New York Infirmary makes this citation of Dr. Josephine B. Neal in recognition of her distinguished achievement in the control of communicable disease. Dr. Neal will always be identified as one of the great figures in medicine and public health, particularly in

JOSEPHINE B. NEAL, M.D., F.A.C.P.

ELLEN C. POTTER, M.D., LL.D., Sc. S.D.

the diagnosis, treatment, and control of infectious diseases of the nervous system. For many years she was in charge of the division of acute infections of the central nervous system of the Department of Health of New York City. Her pioneering work in the diagnosis and treatment of these diseases and her wide experience and knowledge made her an acknowledged leader in the field, so that she was constantly called upon by physicians and hospitals for assistance in the management of such cases. When the Matheson Commission was appointed to investigate epidemic encephalitis, Dr. Neal, logically, was chosen as the executive secretary, and she directed the study which was later published. A woman of unusual energy, she found time to act as clinical professor emeritus of neurology at Columbia University and consultant neuropsychiatrist at Willard Parker Hospital in addition to her other duties; and from 1936 until her retirement she took on the additional burden of associate director of laboratories of the health department. She must have had some spare time, for she has contributed more than seventy articles to leading medical journals. Her associates remember her as a modest woman, kind and warm hearted, with whom it was a pleasure to work. The physicians of the city think of her as a doctor who was ready, at all times, to respond to their calls for help, to see through a problem clearly, and to offer advice generously. She was so closely associated with the study of central nervous system infections that one is apt to lose sight of the fact that she pioneered, as an assistant to Dr. Catherine Kelly at Bellevue Hospital, in the study of the electrocardiograph, an instrument that is now accepted as a matter of course in the diagnosis of heart disease. The New York Infirmary is proud to confer the Elizabeth Blackwell Award on Dr. Josephine B. Neal.

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The New York Infirmary makes this citation of Dr. Ellen Culver Potter in recognition of her outstanding achievement in public health and welfare. Born in Connecticut, of old Colonial stock, she early displayed an interest in medicine. A favorite childhood pastime was to play "doctor" to her dolls. Dr. Potter received the degree of Doctor of Medicine from the Woman's Medical College of Pennsylvania in 1903, and has been a loyal and active alumna ever since. She interned at the Woman's Hospital of Philadelphia, then became chief resident at the newly organized hospital of the Woman's Medical College. She entered private practice and served in clinics and on the wards of hospitals in Philadelphia, also holding positions of increasing importance on the faculty of the Woman's Medical College. It was evident, however, that her chief interest in medicine was to promote health rather than to cure disease. Her talents and ability soon were utilized by the State of Pennsylvania in the Department of Health, where she became chief of the Division of Child Health, then Director of the Bureau of Children, and in 1923 Gov. Gifford Pinchot appointed her Secretary of Welfare of the state. As such, she was the first woman cabinet officer in any state, and was designated by Governor Pinchot as "the best man in my cabinet." Dr. Potter subsequently became director of medicine, Department of Institutions and Agencies of New Jersey, and held this position until 1948. From time to time she was lent to the Federal Government for expert advice on welfare problems. As a woman of broad human sympathies, and a physician of great achievement, she was called upon to serve as President of the American Medical Women's Association, president of the National Conference of Social Work, a member of the board of corporators of the Woman's Medical College of Pennsylvania, and its acting president from 1941 to 1943. She has received the honorary degree of Doctor of Laws from Rutgers University, the W. S. Terry, Jr., Memorial Merit Award, and the degree of Doctor of Social Sciences from the Woman's Medical College of Pennsylvania. The New York Infirmary is proud to confer the Elizabeth Blackwell Award on Dr. Ellen Culver Potter.

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The New York Infirmary hereby makes this citation of Dr. Florence R. Sabin in recognition of her achievement in medical education, anatomy, and public health. Dr. Sabin, a graduate of Smith College, in 1900 received her medical degree from Johns Hopkins University, where for 25 years she was a member of the faculty in the department of anatomy. She was the first woman to hold a full professorship in its School of Medicine. For 13 years a member of the Rockefeller Institute for Medical Research, she retired as a member emeritus in 1938. But retirement, for Dr. Sabin, actually meant only a change from one field of active interest to another. In her native Colorado she successfully exerted unremitting efforts for appropriate legislation for the long overdue reorganization of the state's health department. She subsequently became chairman of the Board of Health and Hospitals in the City and County of Denver, and manager of its Department of Health and Charity. Dr. Sabin's scientific investigations on the blood and

FLORENCE R. SABIN, M.D., D.Sc., LL.D.

IDA S. SCUDDER, M.D., D.Sc., F.A.C.S.

lymphatic systems and on certain aspects of tuberculosis are noteworthy contributions to our biologic knowledge. She is a great teacher and her interest in education has extended far beyond her classes and laboratory. She has served on such important bodies as the committee of awards of the Guggenheim Memorial Fellowships, the board of trustees of the Institute for Advanced Study, and the Finney-Howell Research Foundation, of which she is the president. Her sensitive biography of Franklin P. Mall is not only a beautifully written account of the life of a great anatomist; it is also a reasoned critical consideration of basic elements of medical education. Dr. Sabin has received several honorary degrees and awards; among them an LL.D. and the Lasker Award. A new building of the University of Colorado Department of Medicine, in evidence of the deep respect and great admiration she has always inspired, has been named the "Florence R. Sabin Building for Research in Cellular Pathology." The New York Infirmary is proud to confer the Elizabeth Blackwell Award on Dr. Florence R. Sabin.

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The New York Infirmary makes this citation of Dr. Ida Sophie Scudder, a woman of rare spiritual quality, in recognition of her achievement as a great administrator, educator, and medical missionary. The granddaughter of America's first medical missionary and the daughter of a medical missionary, Dr. Scudder was born in India and educated in America. Having knowledge of the agonies and deaths of Indian women in childbirth, whose religion forbade them the services of men physicians, she renounced her desire to go to Wellesley, and became a doctor, with the express purpose of working among women in India. Dr. Scudder graduated from Cornell Medical School, after beginning her studies at the Woman's Medical College of Pennsylvania, and immediately began to raise money for the establishment of a hospital at Vellore, India. This hospital was begun in 1900 with a room eight by twelve feet for a clinic, and six beds in a neighboring house. It is now a large and busy institution. In addition, Dr. Scudder established a tuberculosis sanitarium and, for patients who could not come to Vellore, a roadside dispensary service, with which she travelled by train, carriage, or pony cart. In 1918 Dr. Scudder obtained the consent of the Surgeon General to start a medical school for women. This is now a large, well equipped, government approved school that has graduated hundreds of doctors and nurses. Her work is known all over the world. Her patients call her "a light shining in dark places." She has been honored by the British Government with the gold Kaiser-I-Hind Medal with Gold Bar, by Rutgers University with the honorary degree of Doctor of Science, and by the American College of Surgeons as an honorary Fellow. Dr. Scudder, addressing a graduating class of the medical school which she founded, said, "Make yourselves workmen that need never be ashamed." The New York Infirmary is proud to confer the Elizabeth Blackwell Award on Dr. Ida Sophie Scudder, a "workman that need never be ashamed."

### ANITA M. MÜHL, M.D.

Dr. Anita Muhl died December 14, 1952, at the age of 66. She was a psychiatrist of international reputation. A graduate of the University of Indiana Medical School, she also received a Ph.D. from George Washington University. Dr. Mühl held psychiatric positions with the United States Medical Service, and with the State Department of Education. During her career, she taught psychiatry and criminology at the University of Melbourne (Australia), and in Australian clinics for three years. She was the author of three books on criminology and automatic writing. Dr. Mühl was a member of numerous medical societies as well as an honorary member of the International Mark Twain Society.

CONNECTICUT. MARY GRAY received her M.D. degree from the Long Island College of Medicine in 1952. She is the only woman intern to be appointed to the staff of St. Francis Hospital in Hartford, Connecticut, this year.

ILLINOIS. The DR. BERTHA VAN HOOSEN geriatrics ward at the Women and Children's Hospital, dedicated September 30, believed to be the first of its kind in Chicago devoted to the exclusive use of the aged, was equipped and sponsored by the Ladies in Blue, volunteer nurses' aides. The late Dr. Van Hoosen served on the staff of the hospital for 50 years.

The Chicago Ophthalmological Society held its annual clinical conference recently. DR. GEORGIANA THEOBALD of Oak Park, took part in a symposium on aqueous humor.

MINNESOTA. LT. COMDR. CARRIE E. CHAPMAN, M.C., USNR, a former fellow in the Mayo Foundation, returned recently from London where she attended the International Congress of Physical Medicine at Kings College. Dr. Chapman is now serving with the United States Navy at the Oakland Naval Hospital, Oakland, California.

The Sixth Annual Minnesota Public Health Conference was held in Saint Paul recently. DR. MARY GIFFIN of the Mayo Clinic participated in the program.

DR. HELENE KNUTSON, director of Hospital Service in the state for the Minnesota Department of Health, spoke to a joint meeting of the County Public Health Nursing Advisory Board and the Registered Nurses Club. Her talk concerned the increasing aged population.

NEW YORK. DR. CONNIE M. GUION has been elected an honorary governor of New York Hospital, where she is a consultant in medicine and a member of the medical board. It is the first time in the 181 year history of the hospital that a woman has been elected an honorary governor. Dr. Guion has been chief of the general medical clinic of the hospital since 1932. She is a graduate of Cornell Medical College.

DR. JOSEPHINE H. NORTON, associate attending physician at Knickerbocker Hospital in New York City, has been appointed an assistant university physician at New York University in charge of coordinating the health counseling and medical services at the School of Education.

The New York City Department of Health is sponsoring weekly seminars on new developments in medical practice for the general practitioner. On February 21, DR. ZIRA DEFRIES discussed "Convulsive Disorders in Children." Dr. DeFries was graduated from New York Medical College.

Recently DR. EDITH L. POTTER, associate professor of pathology in the department of obstetrics and gynecology, University of Chicago, addressed the joint meeting of the Medical Society of the County of Erie, the Women Physicians' League of Buffalo, and the Elizabeth Blackwell Society at the Hotel Statler, Buffalo. Dr. Potter discussed neonatal mortality and pathology.

The fiifth-sixth clinical session of the Tuberculosis Sanatorium Conference of Metropolitan New York was held at Cornell University Medical College recently. The topic of discussion was, "The Solitary Tuberculous Focus: Bronchial Relations to Solid Necrotic Tuberculous Lesions." Among the speakers was DR. JULIA JONES of Bellevue Hospital, New York City.

DR. WINIFRED P. LOUGHLIN has been elected secretary of the New York Diabetes Association.

DR. MARCELLE BERNARD of New York City was moderator of a panel discussion on "Education and Opportunities for Women in Medicine." The discussion was presented to the members of the Manhattan Business & Professional Women's Club at a recent meeting. Dr. Bernard is chairman of the Public Health Committee. Among the panel members were DR. LURIE PAULTRE of Haiti; DR. VALERIA STARK of Israel; DR. LUCIE RUDD of New York; DR. LENA BROWN of Jersey City; DR. GLORIA SANCHEZ of Philippine Islands; and DR. ADA CHREE REID, president, Medical Women's International Association.

On January 29, in commemoration of the ninety-sixth anniversary of the founding of the New York Infirmary, and to honor its founder, DR. ELIZABETH BLACKWELL, Representative Arthur G. Klein (D), of New York, introduced a bill for a commemorative five cent stamp in her honor. "This stamp," said Representative Klein, "will honor this woman who pioneered in the medical field, so that other women could take their natural place in healing the wounds of those in pain. She has set a standard of accomplishment and achievement to all women. Her wise and kindly devotion to her work and her great love for humanity have illumined the pathway for others to follow."

WISCONSIN. More than twenty years of service to northwoods residents in Oneida and Vilas counties were recently recognized when DR. KATE PELHAM NEWCOMB, Woodruff, was honored by the Arbor Vitae-Woodruff Lions Club at a testimonial dinner, at which she was awarded a plaque for community service.

HELEN BROOKE TAUSSIG, M.D.

### General

Dr. Helen Brooke Taussig of Johns Hopkins University, received the medal of the American College of Chest Physicians for her outstanding achievement in diseases of the chest. Dr. Taussig is the first woman to receive the College medal.

The first "blue baby" operation by Dr. Alfred Blalock at the Johns Hopkins in November 1944 was a momentous event in the career of Dr. Taussig. It was the first step in proving the value of her idea for saving and prolonging the lives of children with malformed hearts. She had suggested the unprecedented operation to the surgeon, and the daring techniques they had worked out together brought instant fame to both of them.

Since that time she has received many honors. She received the Passano Foundation Award for an outstanding contribution to science. She was voted the outstanding woman of science by the Associated Press newspapers. She was cited for her contribution "to the glory of her profession" by Hobart College, Geneva, New York.

### International

*Great Britain:* Dr. Catherine Chisholm, the first woman to be accepted as a medical student by Manchester University, bequeathed an estate of £17,600. After a few legacies she left one half of the residue for the promotion of research into the health and diseases of infants, to be known as "The Alice Chisholm Fund" in memory of her sister, and one half of it "to the Victoria University of Manchester to be applied in or towards the endowment of the School of Child Health in or attached to that University."

## THESE WERE THE FIRST

Anna Commena, of Constantinople, studied and taught and knew all that was to be known of medicine in the eleventh century. She aided in founding a medical school and wrote 15 volumes on the history of medicine.

Dr. Cleora Augusta Seaman, born in Middlebury, Vermont, moved with her family to Cleveland, Ohio. After attending lectures at the Woman's Medical College of Pennsylvania while on a visit to Philadelphia, she returned to Cleveland and received her medical degree from the Western College of Homeopathy in 1860, the only woman in her class. Dr. Seaman assisted in establishing the Cleveland Homeopathy College and Hospital for Women in 1867 which merged with the Western College of Homeopathy three years later. The Seaman Free Dispensary was founded in 1869.

Dr. Dora Brucke-Teleky, first medical woman on the surgical staff of the noted Professor Eiselberg's clinic in Vienna and the first school physician in Austria, also the first medical woman in her country to be elected to the scientific society, Gesekschaft Der Aertztz, of Vienna, was a member of the municipal council of that city. Dr. Brucke-Teleky founded the Vienna Medical Woman's Association of which she was president for ten years, and also founded the Mothers' Welfare and Birth Control Clinic in Vienna of which she was the first president.

Dr. Mary B. Bradford, graduate of the Woman's Medical College of Chicago in 1887, was the first woman physician to go to Persia, in 1888, and for many years served in Tabriz where she did remarkable and courageous work during a terrible epidemic of cholera.

Antiochis, a woman physician of Greece in the second century A.D., was the "daughter of Diodotos of Tlos, honored by the Senate and the people for her skill in the art of medicine" . . . this inscription was found on a limestone tablet in Tlos but the statue itself was lost.

—Elizabeth Bass. M.D.

# BOOK NOTICES

(Editor's Note:—These reviews represent the individual opinions of the reviewers and not necessarily those of the members of the Editorial Board of the JOURNAL.)

**RYPINS' MEDICAL LICENSURE EXAMINATIONS: Topical Summaries and Questions. Walter L. Bierring, M.D., F.A.C.P., M.R.C.P., Edin. (Hon.), Former Member, National Board of Medical Examiners, American Board of Internal Medicine, Iowa State Board of Medical Examiners; Professor Emeritus, Theory and Practice of Medicine, College of Medicine, State University of Iowa. With the Collaboration of a Review Panel. Seventh Edition. Pp. 856. Price $8.00. J. B. Lippincott Company, Philadelphia, 1952.**

It is refreshing to note that the seventh edition of this popular book, as did its predecessors, regards the young medical graduate as a mature, well informed individual. The editor has recognized the continuing trend toward specialization in all fields and in consequence has invited an outstanding group of teachers and clinicians to help him bring the subject matter of their respective fields up to date.

In place of the old style question-and-answer approach, this volume contains a summary of a vast amount of material. The style and arrangement throughout are attractive and lend interest to what is generally considered a chore on the part of the young medical graduate approaching a licensure examination. Thus, the young physician is stimulated to think rather than to memorize the answers to the favorite yet outmoded questions still found in some examinations.

The book is divided into two parts. Part one covers the basic medical sciences and part two the clinical sciences. In this edition the title of Chemistry has been very properly changed to "Bio-Chemistry"; Bacteriology to "Micro-Biology" and Hygiene and Preventive Medicine to "Preventive Medicine and Public Health." The sections dealing with physiology, surgery, and medicine are particularly well presented. Surprisingly little overlapping and repetition were noted by this reviewer.

For the candidate who prefers to take up each subject in order and then test his knowledge, a brief list of well selected key questions is presented at the end of each chapter.

As a whole, this volume maintains its high standard and can be read with profit by both examiner and examinee.

—William G. Leaman, Jr., M.D.

**ROENTGENOLOGY IN OBSTETRICS AND GYNECOLOGY. By William Snow, M.D., Chief Radiologist, Veterans Hospital; Consulting Radiologist, Willis-Knighton Memorial Hospital and Clinic, Shreveport, Louisiana; formerly Director of Roentgenology, The Harlem Hospital, The Bronx Hospital, New York. Second Edition. Pp. 363, 273 figures. Price $10.50. Charles C Thomas, Springfield, Illinois, 1952.**

The first edition was published as "Clinical Roentgenology of Pregnancy." This second edition has been not only revised, but also increased in scope to include roentgenology in gynecology. Much material has been added to the original edition.

Roentgenology in obstetrics and gynecology has grown into a large and special field of study. The subject matter is covered from technique to recovery of tissues from radiation. Chapters on obstetric roentgenology deal with technique, pelvic architecture, usual occipital presentations, atypical presentations; and factors which influence them, the fetus, soft parts (placenta, uterine wall, amniotic fluid), placenta praevia, premature separation, extrauterine pregnancy, and size of uterus.

The author then branches out into hysterosalpingography, internal genitalia and urinary tract, internal genitalia and G.I. tract, growths in the pelvis, roentgen study in bleeding with pregnancy, and recovery of tissue from radiation.

In pelvimetry, the recommended four film study delivers approximately 5r into the uterus. This appears to be within a wide margin of safety.

This book is written in a simple, illustrative style, which makes it easily comprehensible to obstetrician-gynecologists, radiologists, and other students of this subject.

—D. C. Arnois, M.D.

**ESSENTIALS OF DERMATOLOGY. By Norman Tobias, M.D., Associate Clinical Professor of Dermatology, St. Louis University; Assistant Dermatologist, Firmin Desloge and St. Mary's Hospitals; Visiting Dermatologist, St. Louis State Hospital. Fourth Edition. Pp. 596, 186 figures, 6 subjects in color on 3 plates. Price $6.00. J. B. Lippincott Company, Philadelphia, 1952.**

This is the fourth edition in nine years of this compact, readable text of dermatology, a fact which attests to its popularity and usefulness. Dr. Tobias has succeeded in compiling a manual which is an adequate text for medical students and a convenient reference book for the general practitioner. An introductory chapter summarizes some of the basic facts of skin physiology, bacteriology, and so forth, as well as some of the cutaneous expressions of systemic disease. The various diseases are conveniently grouped with introductory paragraphs summarizing the normal functions of the structures discussed. The chapters on syphilis, including one on serologic interpretation, are compact, factual, and go into sufficient detail to aid the student in this often very confusing subject. The photographs are well selected and well reproduced. Better grouping and improved captions might enhance the value of some of the illustrations.

Perhaps the weakest feature of the book is the portions on therapy, which are in some cases antiquated, (use of the actual cautery), including drugs and methods of therapy open to question (mercuric chloride for wet dressings, lotion of lead and opium). The absence of detailed instructions for, e.g., the preparation of an efficient wet dressing, seems to the reviewer a serious omission in a book intended for the instruction of the medical student and nurse. The listing of many proprietary drugs (often misspelled) without explanation of their composition, the failure to indicate preferred methods of therapy when a list of therapeutic procedures is given, the omission of a short section on cutaneous detergents and on various types of newer ointment bases, constitute a serious defect in an otherwise admirable teaching text.

All in all, for its purpose as an elementary teaching text, the volume fulfills its purpose well.

—Carmen C. Thomas, M.D.

**SEX AFTER FORTY: By S. A. Lewin, M.D., and John Gilmore, Ph.D., with an introduction by The Reverend Dr. Russell L. Dicks, Professor of Pastoral Care, Duke University. Pp. 200. Illustrated. Price $3.50. Medical Research Press, New York, 1952.**

This book has numerous line drawings and illustrations to supplement a very clearly expressed and well organized text. The chapters are short and full of common-sense directions. Another of the book's merits

is that it is written to husband and wife together as partners in marriage.

The change of life is discussed as applied to both sexes. The normal aging process is described. The importance of maintaining one's appearance and the development of diversified interests is stressed in a clear and diverting fashion. The importance of the maintenance of good health and the understanding of one's bodily symptoms is stressed. The problems of emotional insecurity are covered. An excellent feature of this book is a list of agencies which can be consulted by those living far from competent help. Various agencies for marriage counseling are listed.

The final chapter is devoted to short and clear summaries of case histories of typical families in which one or the other partner is experiencing symptoms of the climacteric. There is a glossary of words which may be unfamiliar to the average layman. The whole book handles a difficult problem with good taste and common sense. It should be on the shelf of every library for adults.

—Mary DeWitt Pettit, M.D.

**APPLIED PHYSIOLOGY. By Samson Wright, M.D., F.R.C.P., John Astor Professor of Physiology, University of London, Middlesex Hospital Medical School; with the collaboration of Montague Maizels, M.D., F.R.C.P., Professor of Clinical Pathology, University of London, University College Hospital Medical School; and John B. Jepson, D.Phil., A.R.I.C., Senior Lecturer in Biochemistry, Courtauld Institute of Biochemistry, Middlesex Hospital Medical School. Ninth Edition. Pp. 1190, 688 figures. Price $9.00. Oxford University Press, New York, 1952.**

The reappearance of Samson Wright's "Applied Physiology," this time in its ninth edition, is a welcome event not only to medical physiologists but also to up-to-date clinicians who will find it an invaluable reference book. The condensation of so much information into one volume is no small feat. The accuracy with which controversial subjects are assessed and with which current trends are reported is an even greater achievement.

The material is presented in eleven sections which would appear to be conventional divisions. Wright is not bound by convention, however, in his arrangement of the material. Included in the first section, "Regulation of Constancy of Internal Environment," discusses not only fluid and electrolyte balance but also the roles of the kidney and of the posterior lobe of the pituitary in this regulation. Under the topic, "Autonomic Nervous System," visceral sensibility, micturition, adrenal medulla, and hypothalamus are discussed. More questionable inclusions are those of muscle physiology and of regulation of body temperature in the section on respiration.

Much of the material is written in outline form which facilitates review but makes reading of large sections difficult. To some extent this is relieved by the author's sense of humor which caused him to include timely anecdotes and quotations. This is not a physiology textbook for medical students; it contains too much rich material for digestion by beginners. It is, on the other hand, the book of choice for those who want a reliable review and reference in the field of physiology.

—Esther L. McCandless, Ph.D.

**THE LOW FAT DIET COOK BOOK. By Dorothy Myers Hildreth, Consultant Dietitian, University of Pennsylvania Robinette Foundation, Heart Clinic; and Eugene A. Hildreth, M.D., Fellow, United States Public Health Service. Introduction by Francis C. Wood, M.D. Pp. 136. Price $2.95. Medical Research Press, New York, 1952.**

This simple, clearly written diet guide, accompanied by taste tempting recipes, should be most welcome to the patient whose physician has prescribed a low fat diet. The cookbook is based on recent research indicating that the cholesterol level in the blood, which seems to be responsible for arteriosclerosis, is influenced, not by the amount of cholesterol eaten, but by the total fat in the diet. The diet recommended by these authors contains 25 to 35 grams of fat a day which is generally conceded to be the lowest restriction of fat consistent with a palatable menu and good clinical results.

Mrs. Hildreth deserves praise for her imagination and skill as a cook. The recipes she has developed should delight even the gourmet. Variety in foods is achieved by extensive use of spices, herbs, and condiments. Many of the recipes would appeal only to those people who like food highly seasoned. Emphasis on these spicy flavorings contraindicate the use of this book by patients following a low fat diet for any type of digestive disorder, liver or gallbladder disease.

It is regrettable that the plan for a basic low fat diet does not list foods in a way that would aid the patient in selecting a nutritionally adequate diet. More emphasis might have been made on foods which are high in protein, mineral, and vitamin content but low in fat. Also questionable from the nutritional standpoint is the use of mineral oil salad dressings.

—Mildred Kaufman

**GYNECOLOGIC AND OBSTETRIC PATHOLOGY: with Clinical & Endocrine Relations. By Emil Novak, M.D., D.Sc., F.A.C.S., F.R.C.O.G., Assistant Professor Emeritus of Gynecology, The Johns Hopkins Medical School; Gynecologist, Bon Secours and St. Agnes Hospitals, Baltimore; Fellow and Past President, American Gynecological Society. Third Edition. Pp. 595, with 630 illustrations, 19 in color. Price $10.00. W. B. Saunders, Philadelphia, 1952.**

This new third edition of Dr. Novak's book emphasizes its position as a classic reference for the medical student, the practitioner, the gynecologist and the pathologist. It is indeed a difficult task to write a book with such a wide appeal and usefulness, and with the concise organization of material which is the essence of this volume.

The introduction of each chapter with paragraphs on basic knowledge, though probably of little use to an experienced pathologist, makes the book more workable and complete to the student and to the practitioner. For example, the clinician interested in hydatidiform moles may review his basic knowledge of "Implantation and Placentation" in chapter 32 and then turn to chapter 33 and review, not only the gross and microscopic pathology of hydatidiform moles, but also the clinical manifestations of this problem and the interpretation of diagnostic tests used by the clinician.

An appeal is made for adequate cervical biopsy, with comments on methods, and an explanation of the responsibility of the clinican to furnish a proper specimen to the pathologist.

The addition of the last chapter on the "Common Lesions of the Breast" will be welcomed by the busy obstetrician-gynecologist who is frequently consulted by the woman with a breast lesion.

An adequate reference list at the end of each chapter enhances the usefulness of the book to the pathologist and the experienced gynecologist. The author is to be congratulated on his fine collection of illustrations, many of which are in color.

—Alma Young, M.D.

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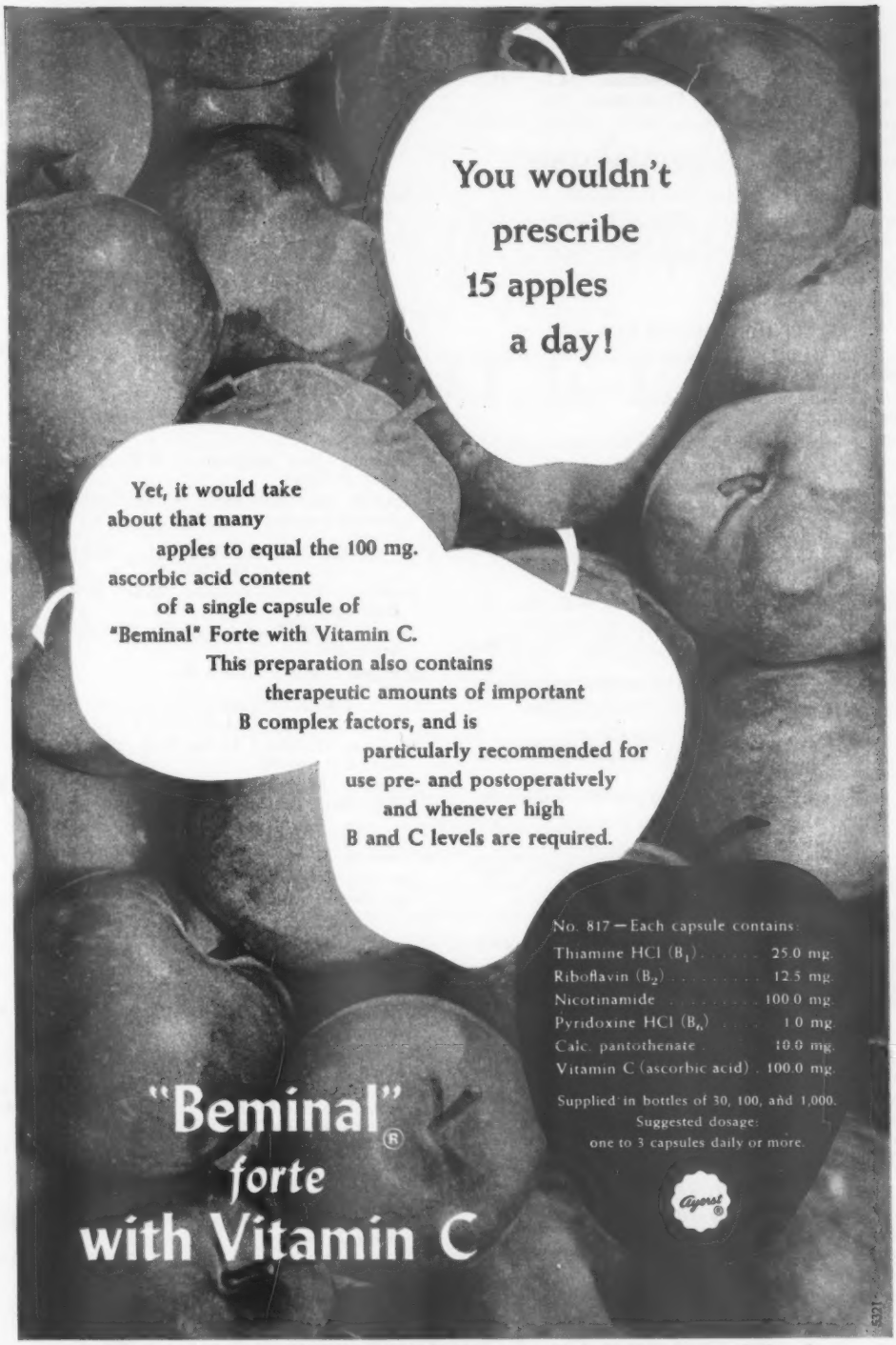
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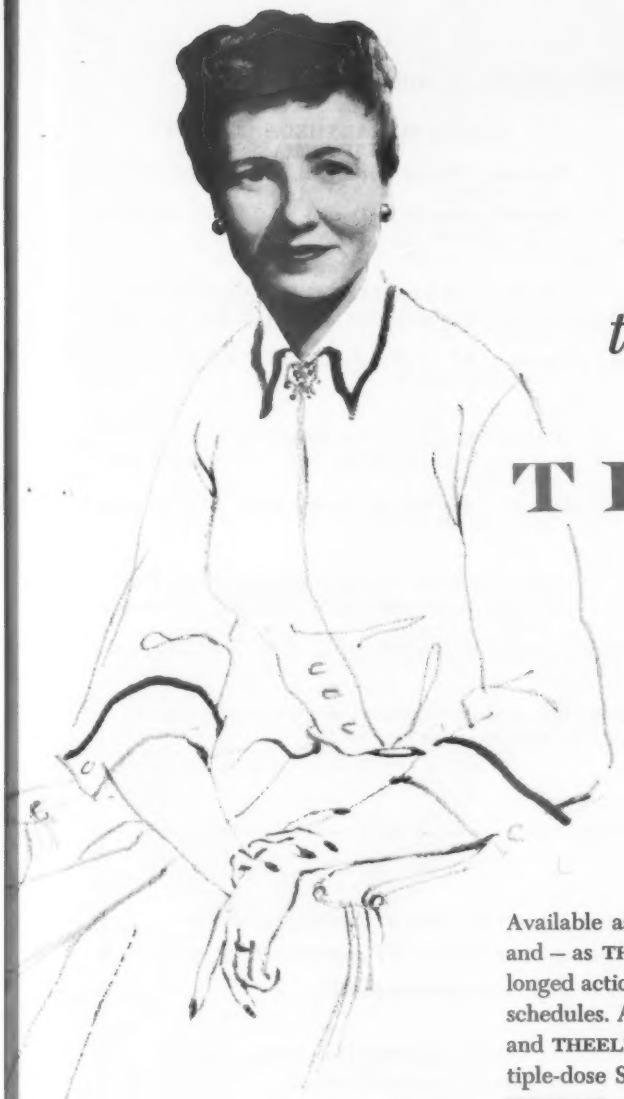

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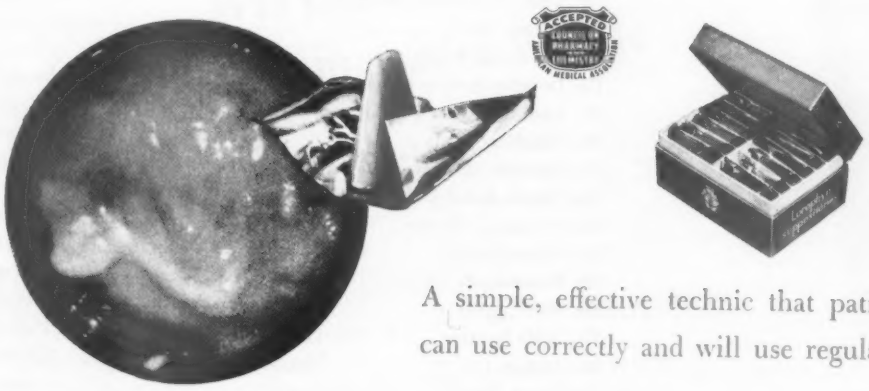


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AMERICAN CANCER SOCIETY

# Will you help them grow up in a safer world?

Ask a man if he loves his child, and you know the answer before he gives it. Yet no child today is safe from cancer—some time during his life.

Cancer can kill children—*no* age is free from this terrible scourge. Cancer can rob them of the love and care of a mother—a father—or both.

Won't you help us in the fight against this terrible scourge?

***The American Cancer Society needs money.*** Money to aid doctors in problems of diagnosis and treatment, to provide for costly research, to ease the suffering of cancer victims.

Our weapons are your dollars and cents; the victory is a better world for all our children.

Send a contribution today to Cancer, c/o your Local Post Office. Thank you.

**CANCER STRIKES 1 IN 5**

***STRIKE BACK—GIVE TO CONQUER CANCER!***

# News Notes From Our Advertisers

M & R Laboratories, producers of *Similac*, in a recent issue of their "Currents in Infant Care," report briefly on a study by A. E. Axelrod* of Western Reserve University. This study gives evidence that certain B vitamins play a significant role in antibody synthesis. In a series of experiments relating vitamin intake to the process of antibody formation in rats, the investigator noted a severely decreased antibody response in pyridoxine deficiency. Equally severe impairment of antibody production was observed in pantothenic acid and pteroylglutamic acid deficiencies. Inhibition was moderate in riboflavin, thiamine, biotin, vitamin A, and niacintryptophane deficiencies. No effects were seen in vitamin $B_{12}$ or D deficiencies.

*Metabolism 2:1 (January) 1953.

* * *

Merck & Co., Inc. has announced the availability on prescription through regular distributive channels of *Duo-Strep*, the Merck brand of mixed antibiotic product composed of equal percentages of crystalline dihydrostreptomycia and streptomycin sulfates. *Duo-Strep* is recommended for use in the treatment of tuberculosis in combination with para-aminosalicylic acid or other chemotherapeutic agents. *Duo-Strep* is said to be useful in treatment of pneumonia caused by Hemophilus influenzae, tularemia, brucellosis with bacteremia (supplemented by sulfadiazine therapy), plague, and certain venereal diseases. It is also useful in treatment of granuloma inguinale, subacute bacterial endocarditis, urinary tract infections due to gram-negative bacilli, and gastrointestinal surgery for prophylaxis.

Additionally, this company offers a new formulation of *Cortone*, the Merck brand of cortisone, with an antibiotic, for treatment of certain diseases of the eye. The new product is *Ophthalmic Ointment of Cortone Acetate with Bacitracin*, which combines the anti-inflammatory activity of *Cortone* with the antimicrobial activity of bacitracin against susceptible organisms. This product permits the simultaneous application of *Cortone* with an antibiotic, two agents that have found a definite place in the treatment of certain eye disorders by the ophthalmologist.

* * *

Parke, Davis & Company has announced a new type of surgical sponge, detectable by x-ray. Called *Ray-X*, these sponges incorporate a barium sulphate insert that is permanently fused to the gauze and detectable under x-ray. They are available in four sizes and are soft, non-toxic, pliable, and non-abrasive. They can be sterilized in the usual manner and no special x-ray techniques are required when using *Ray-X*.

Another Parke, Davis & Company product, *Elixir Benadryl*, is reported to be satisfactory in the treatment of primary behavior disorders in children, especially in those patients who show considerable anxiety. Two New York physicians, Dr. A. S. Effron and Dr. A. M. Freedman* report that children with sleep disturbances, especially night terrors, seem to obtain rapid relief from symptoms with a general improvement in behavior. No toxic symptoms were observed in any of the children due to administration of the drug, the physicians said. These doctors noted a reduction in manifest anxiety in 54 percent of the cases; an improvement in the child's relationship with adults was found in 56 percent of the cases; and 44 percent of the children showed improved relationship with other children.

*Journal of Pediatrics, 42: 261, 1953.

Ciba Pharmaceutical Products, Inc. has announced that it will present five prizes of $100 each to the outstanding junior or senior year specialist in the five departments of the Division of Science of Drew University.

* * *

Chas. Pfizer & Co. has announced the availability for prescription sales of their orange-flavored *Candettes*—troches containing bacitracin and polymyxin B. They are designed for the control of superficial infections of the mouth and throat. The combination is said to hit a wide range of bacteria and reduces the chance of sensitivity or resistance to a minimum. Polymyxin is effective against gram-negative bacteria; bacitracin against gram-positive. *Candettes* are also suggested for prophylactic use after dental procedures since this antibiotic combination is effective against the majority of organisms found in the mouth.

This company's new anti-tuberculosis drug, *Streptohydrazid*, combines two of the most effective anti-tubercular agents, streptomycin and isoniazid. Streptomycin is now the standard weapon against tuberculosis while isoniazid, announced last year, has rapidly assumed a position of importance as an additional therapy.

* * *

Hoffmann-La Roche Inc. has made available their new synthetic narcotic *Levo-Dromoran Tartrate 'Roche'* which is said to be twice as potent as the original *Dromoran (dl) Hydrobromide*. *Levo-Dormoran Tartrate* will eventually replace *Dromoran (dl) Hydrobromide*. This drug is morphine-like in action, but provides longer-lasting relief of severe pain and causes fewer side reactions such as hangover, nausea, and constipation.

* * *

The Upjohn Company has developed a new form of therapy for the treatment of infectious diarrhea—*Kaopectate* combined with neomycin. One clinical report* indicated that *Kaopectate* with neomycin was 87 percent effective in a group of 72 infants under 1 year of age.

*Dr. Oscar Felsenfeld's study conducted in Jamaica, British West Indies, under the auspices of the Tropical Research Foundation.

* * *

A product of Winthrop-Stearns Inc., *Levophed*, a vaso-constrictor, is reported to have raised and maintained blood pressure in 42 of 44 cases from shock levels.* The 44 patients in shock consisted of 14 with myocardial infarction, 9 with overwhelming infection, 6 with excessive hypotension secondary to medication, and 15 in surgical shock. All the patients had previously failed to respond to adequate fluid replacement and blood transfusions. Due to the satisfactory pressor response with *Levophed*, all the surgical patients recovered who did not have fatal complications such as infection, intravascular hemolysis or pancreatitis.

*Findings reported by Dr. James M. Skelton, at the centennial anniversary meeting of the Texas State Medical Association based on clinical studies conducted at Baylor University College of Medicine in association with Dr. John H. Moyer and Dr. Lewis C. Mills.

# Why Obedrin

## . . . for the obese patient ?

*Because*

Obedrin offers a practicable solution to the problem of keeping an obese patient on a restricted diet.

*Because*

Thousands of enthusiastic physicians have found that Obedrin curbs the appetite without making the patient jittery and does not cause insomnia.

*Because*

Obedrin contains enough vitamins to supplement the restricted diet. A large dose of vitamin C is included to help mobilize tissue fluids.

*Because*

Obedrin contains *Pento*barbital, a short-acting barbiturate, as a corrective. Pentobarbital has approximately the same duration of action as methamphetamine, so the possibility of cumulative barbiturate effect is negligible.

**Available: The 60-10-70 Diet.*** This is a convenient, variable diet, with enough roughage to eliminate necessity of artificial bulk laxatives.

Write for Pads of daily Menus of the 60-10-70 Diet* and [illegible] of Obedrin

Each Obedrin tablet contains:

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|---|---|
| Semoxydrine HCl (Methamphetamine HCl) | 5 mg. |
| Pentobarbital | 20 mg. |
| Ascorbic Acid | 100 mg. |
| Thiamine HCl | 0.5 mg. |
| Riboflavin | 1 mg. |
| Niacin | 5 mg. |

**THE S. E. MASSENGILL COMPANY • BRISTOL, TENN.**

## EDITORIAL FORECAST

### July 1953

The July number of the JOURNAL will be the annual World Health Organization number, commemorating the formation of this important agency of the United Nations. Articles describing past accomplishments and future plans for the improvement of health of all peoples of the world have been written especially for the JOURNAL by staff members of WHO.

"The work of WHO on Virus and Rickettsial Diseases," by A. M.-M. Payne, M.D., M.R.C.P.

"Environment and Health," by R. N. Clark.

"WHO and Afghanistan," by R. L. Tuli, M.D.

There will be articles on medical women around the world, and a summary of the annual report of the Director-General on World Health Organization Activities of 1952.

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## HISTORICAL INFORMATION

**For The Establishment of Permanent Historical Records Concerning Members of the American Medical Women's Association**

Name ..... Address .....
City ..... State .....
Single ..... Married ..... Widow ..... Children .....
College ..... Graduation year .....
Graduate study ..... Further degrees .....
What have you practiced? ..... Where? .....
Organizations to which you belong .....
Offices held .....
Institutions with which you are, or have been, associated .....
.....
Hospital staff .....
Specialty ..... Further study ..... Dates .....
Research .....
Other types of professional activities .....
Special clinical projects .....
Publications .....
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Honors .....
Civic activities .....

Date .....

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GULIELMA FELL ALSOP, *Chairman,* Historical Committtee

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There's no unpleasant liver odor or taste. Each triple-coated, compressed tablet has an outer sugar coating to mask the iron.

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the average daily therapeutic dose for adults, supply:

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| (representing 210 mg. elemental iron, the active ingredient for the increase of hemoglobin in the treatment of iron-deficiency anemia.) | |
| **PLUS THESE NUTRITIONAL CONSTITUENTS:** | |
| Thiamine Mononitrate (6 times MDR*) | 6 mg. |
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| Ascorbic Acid (5 times MDR*) | 150 mg. |
| Pyridoxine Hydrochloride | 3 mg. |
| Pantothenic Acid | 6 mg. |
| →Vitamin $B_{12}$ | 30 mcg. |
| Folic Acid | 3.6 mg. |
| Stomach-Liver Digest | 1.5 Gm. |

*MDR—Minimum Daily Requirement
†RDA—Recommended Daily Dietary Allowance

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*Journal of the*
AMERICAN MEDICAL WOMEN'S ASSOCIATION

## GENERAL INFORMATION

THE JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION is the official organ of the American Medical Women's Association and is issued monthly the 15th of each month.

**CONTRIBUTIONS**—THE JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION extends an invitation to the profession for articles on original investigation, for reviews, case reports, articles of historical interest—especially those dealing with the status of women physicians, biographies of women in medicine, and any other material on subjects of special concern to women physicians. All manuscripts for publication, letters, and all communications relating to the editorial management of the JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION should be sent to the Editor at the address below.

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**ILLUSTRATIONS**—Illustrations must be in the form of glossy prints or drawings in black ink. On the back of each illustration the figure number, author's name, and indication of the top of the picture must be given. Legends for illustrations must be typewritten in a single list, with numbers corresponding to those on photographs and drawings. THE JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION encourages the use of illustrations and will supply a reasonable number free of cost; special arrangements must be made with the Editor for excess illustrations or elaborate tables. The Editor is not responsible for the safe return of manuscripts and illustrations. All material supplied for illustrations, if not original, should be accompanied by reference to the source and permission for reproduction from the owner of copyright. Recognizable photographs of patients should carry with them written permission for publication.

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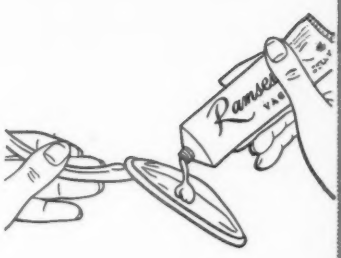


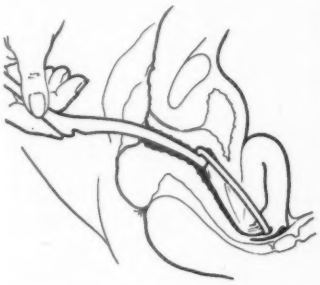

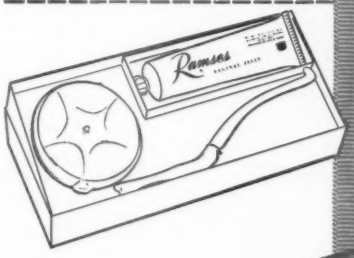


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1. Report to Council on Pharmacy and Chemistry, A.M.A.: J.A.M.A. 148:50 (Jan. 5) 1952.

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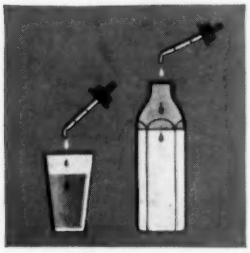

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Disperse readily in formula, fruit juice or water. Mix well with cereals, puddings or strained fruits.

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Light, clear and non-sticky. Can be accurately measured and easily administered. No mixing necessary.

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Require no refrigeration. May safely be autoclaved with the formula.

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